016647 DEC 1988

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36719 REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: CHARLES | MIDDLE: WARREN | LAST: BARGER | 2a. DATE OF DEATH MONTH DAY YEAR: 11 24 88 | 2b. HOUR: 2.35 PM | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR: APRIL 6, 1926 | 6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: FREDERICK MD. | | |
| 10. CITY OR TOWN OF DEATH: FREDERICK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FREDERICK MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ESTIMATOR | 12b. KIND OF BUSINESS OR INDUSTRY: ELECTRICAL | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD | 13b. COUNTY: FREDERICK | 13c. CITY OR TOWN: FREDERICK | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET ADDRESS: 7987 CLIPPER COURT 21701 | |
| 14. FATHER'S NAME FIRST: ANDREW | MIDDLE: FRANCIS | LAST: BARGER | 15. MOTHER'S MAIDEN NAME FIRST: ANNA | MIDDLE: | LAST: PAYNE |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES (IF YES, GIVE WAR OR DATES): WW II | 16b. SOCIAL SECURITY NO.: 577-32-4837 | 17. INFORMANT: Shirley A. Barger | ADDRESS: Frederick, MD 7987 Clipper Court | | |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiorespiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Septicemia

DUE TO, OR AS A CONSEQUENCE OF (c): Metastatic Renal cell carcinoma

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Severe Leukopenia

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 8/1 19 88, to 11/24 19 88, that (I) (we) last saw the deceased alive on 11/22 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: Andrew G. Mankus | DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED: 11/25/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): ANDREW G. MANKUS M.D. | 22e. ADDRESS: 187 Thos Johnson Dr. Frederick MD. 21701 | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: 11/28/88 | 23c. NAME OF CEMETERY OR CREMATORY: RESTHAVEN MEM. GARDENS | 23d. LOCATION CITY OR TOWN: FREDERICK | COUNTY: FREDERICK STATE: MD |
| 24. FUNERAL DIRECTOR NAME: G. DOUGLAS STAUFFER ADDRESS: 1621 Opossumtown Pike, Frederick, MD 21701 | | 25a. DATE REC'D BY REGISTRAR: DEC 1 1988 | 25b. REGISTRAR'S SIGNATURE: [signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 9

DHMH - 16 50M 1/81 (VRA 15, 4)

018163 JAN -3

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36720 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Charles Middle: Shepherd Last: Bayles | | | | 2a. DATE OF DEATH Month: 12 Day: 30 Year: 88 | 2b. HOUR 0600 A.M. |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: NOV. 4, DAY 1923 YEAR | 6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS | If under 1 year: Months / Days | If under 24 hrs: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WEST VA. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: FREDERICK | | MD. |
| 10. CITY OR TOWN OF DEATH: FREDERICK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FREDERICK MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): FARMER | 12b. KIND OF BUSINESS OR INDUSTRY: FARM | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE: MD. | 13b. COUNTY: FREDERICK | 13c. CITY OR TOWN: FREDERICK | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 10110 GAS HOUSE PIKE 21701 | |
| 14. FATHER'S NAME First: CHARLES Middle: S. Last: BAYLES SR. | | | 15. MOTHER'S MAIDEN NAME First: VIRGIE Middle: - Last: PENWELL | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES | (IF YES, GIVE WAR OR DATES): WWII | 16b. SOCIAL SECURITY NO.: 231-22-9119-A | 17. INFORMANT: MARGIE TIGNER | ADDRESS: SAME as # 13 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a): Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO, OR AS A CONSEQUENCE OF (b): lung cancer (adeno-carcinoma) — 1 month

DUE TO, OR AS A CONSEQUENCE OF (c): cigaret smoking — 45 YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Allen J. Gilson | DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | | 22c. DATE SIGNED: 12/30/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Allen J. Gilson MD | 22e. ADDRESS: 1475 STANLEY AVE | FRED | MD |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: JAN. 3, 1989 | 23c. NAME OF CEMETERY OR CREMATORY: LAYTONSVILLE | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: LAYTONSVILLE MONT. MD. |
| 24. FUNERAL DIRECTOR NAME: MURIEL H. BARBER | ADDRESS: LAYTONSVILLE, MD. 20879 | 25a. DATE RECEIVED BY REGISTRAR: JAN 3 1989 | |

DHMH - 16 50M 1/81 (VRA 15, 4)

016503 DEC 16

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36721

1. DECEASED NAME (TYPE OR PRINT): FIRST Sean; MIDDLE William; LAST Beck

2a. DATE OF DEATH: KNOWN XX ESTIMATED ☐ MONTH 6 DAY 11 YEAR 88 — 2b. HOUR

3. SEX: male — 4. RACE: caucaian — 5. DATE OF BIRTH: MONTH Aug. DAY 21 YEAR 1964 — 6. AGE (IN YEARS LAST BIRTHDAY): 23 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 6 DAY 11 YEAR 19 88 — 2d. HOUR 2:40P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick County MD.

10. CITY OR TOWN OF DEATH: Frederick

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frederick Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): dry wall hanger — 12b. KIND OF BUSINESS OR INDUSTRY: construction

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: Frederick — 13c. CITY OR TOWN: Myersville — 13d. INSIDE CITY LIMITS? YES ☐ NO X — 13e. STREET ADDRESS: 10442 Grindstone run Rd. 21773

14. FATHER'S NAME: FIRST William MIDDLE E. LAST Beck

15. MOTHER'S MAIDEN NAME: FIRST Anastasia MIDDLE LAST Rapp

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 220-60-1556

17. INFORMANT: Lori Beck — ADDRESS: Myersville, Md.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Head injuries
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES XXX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY: HOUR A.M. 6:00PM MONTH 6-9-88 DAY YEAR

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): Subject hit head during fight

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): Driveway

21f. LOCATION: STREET 9202 Myersville Road, CITY OR TOWN Myersville, COUNTY Frederick County, STATE Maryland

22a. I certify that I took charge of the remains described above, held an Autopsy XX Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide XX Undetermined manner ☐.

ACTUAL SIGNATURE: John E. Smialek M.D. — TITLE (SPECIFY): Chief MEDICAL EXAMINER — DATE SIGNED: REISSUED 11-14-88 6-12-88

VC EXAMINER'S NAME (TYPE OR PRINT): John E. Smialek, M.D. — ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 6/14/88 — 23c. NAME OF CEMETERY OR CREMATORY: Grossnickle Cemetery — 23d. LOCATION: CITY OR TOWN Myersville, COUNTY Fred., STATE Md.

24. FUNERAL DIRECTOR: NAME Thompson Funeral Home — ADDRESS Middletown Md. 21769

25a. DATE REC'D. BY REGISTRAR: DEC 14 1988 — 25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM NO. 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

016570 DEC 1988

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 36722

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| ARCHIE | WARD | BENNETT | 12-9-88 | 4:55 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Male | White | 5-15-10 | 78 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Virginia | USA | | Frederick MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Frederick | Citizens Nursing Home | Farmer | Farming |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Frederick | Frederick | YES ☒ NO ☐ | 2200 Rosemont Ave. 21701 |

| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |
|---|---|
| George Bennett | Mary E. Patrick |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 223-40-2108 | (daughter) Catherine Gibson | 510 Thompson St. Taxewell, VA 24651 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO, OR AS A CONSEQUENCE OF (b) Neurosyphilis — 30 years ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic Prostatitis Schizophrenia

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. **I certify** that (I) (this hospital) attended the deceased from Dec 19 88, to 12/9 19 88, that (I) (we) last saw the deceased alive on 12/6 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| James E Stoner Jr. | MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐ | 12/9/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| JAMES E STONER, JR | 228 N MARKET ST, FREDERICK, MD 21703 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12 Dec 88 | Grandview Memory Gardens, | Bluefield, Virginia |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Capitol Funeral Service, Falls Church, VA | DEC 15 1988 | Julia Davidson-Rogers |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

017921 DEC -3 88 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

REG. NO. 88 36723

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: CHARLOTTE Zimmerman Best | | | 2a. DATE OF DEATH MONTH DAY YEAR: December 13 1988 | 2b. HOUR: 0320 AM |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR: March 29 1919 | 6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: FREDERICK MD. | |
| 10. CITY OR TOWN OF DEATH: FREDERICK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FREDERICK MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CLERK | 12b. KIND OF BUSINESS OR INDUSTRY: GOVT/RESEARCH |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | FREDERICK | FREDERICK | YES XX NO ☐ | 1610 ROCK CREEK DRIVE 21701 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| GEORGE ZIMMERMAN | WILMA TROUT |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | N/A | 220-09-6168 | HALLAR BEST | 1610 ROCK CREEK DR. FREDERICK, MD |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Extensive edema of unknown | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Primary | 1 yr |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| ☐ | | |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | | |

22a. I certify that (I) (this hospital) attended the deceased from 12/87 19__ to 12/13 1988, that (I) (we) last saw the deceased alive on 12/12 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/13/88

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| P. GREGORY RAUSCH, MD | 4 W. 7th ST., FREDERICK, MD 21701 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| CREMATION | 12/14/88 | RESTHAVEN MEM. GARDENS | FREDERICK FREDERICK MD |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| G. DOUGLAS STAUFFER 1621 OPOSSUMTOWN PIKE, FREDERICK, MD 21701 | DEC 14 1988 | Julia Davidson-Randall |

BP 10

DHMH - 1650M 1/81 (VRA 15, 4)

048507 JAN -9 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR

REG. NO. 88 036724

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR | |
| Edith | Gladys | BINET | December 30, 1988 | 8:10 P.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS: HOURS, MIN. |
| female | white | Nov. 1, 1900 | 88 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| England | U.S.A | | Frederick MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Frederick | Homewood Retirement Center | Housewife | Home | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Md. | Montgomery | Germantown | YES ☒ NO ☐ | 20529 Anndyke Way 20874 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Charles | Walker | Camwell | Mary | | Pearson |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | WW II | 262-62-7403 | Joan Lavin | Germantown, Md. |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) SEPTICEMIA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) URINARY TRACT infection

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Senile Parkinson's disease. Atherosclerotic Heart Disease

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I) (this hospital) attended the deceased from 6-07, 19 88, to 12-30, 19 88, that (I) (we) last saw the deceased alive on 12-8, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Arthur G. Marked | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/30/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| ARTHUR G. MARKED, M.D. | 187 Thos Johnson Dr. Frederick, MD 21701 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Cremation | Dec. 31, 1988 | Smithsburg Crematory | Smithsburg, Wash. Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Davis Funeral Home | Smithsburg, Md. | JAN 30 89 | Jacke Davidson-Randall |

BP

DHMH-16 SDM 1/81 (VRAD'S, 4)

016635 DEC 19 88 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 036723

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) — FIRST: Robert; MIDDLE: Marion; LAST: BLANK | | | 2a. DATE OF DEATH — MONTH DAY YEAR: December 4, 1988 | 2b. HOUR: 5:09p M |
| 3. SEX: Male | 4. RACE: Caucasion | 5. DATE OF BIRTH — MONTH DAY YEAR: Jan. 20, 1937 | 6. AGE (IN YEARS LAST BIRTHDAY): 51 YRS | IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick County, MD. | |
| 10. CITY OR TOWN OF DEATH: Frederick | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frederick Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Bricklayer | 12b. KIND OF BUSINESS OR INDUSTRY: Construction |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Frederick | Frederick | YES [ ] NO [X] | 7504 Old Receiver Road/21701 |

| 14. FATHER'S NAME — FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST | |
|---|---|---|
| Milton / H. / Blank | Elizabeth / V. / Lowery | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): None | 16b. SOCIAL SECURITY NO.: 214-34-9290 |
| 17. INFORMANT: Mrs. Nancy E. Blank, Frederick, Md. | ADDRESS: 7504 Old Receiver Road Frederick, Md. 21701 | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ventricular fibrillation

DUE TO, OR AS A CONSEQUENCE OF (b): pulmonary edema

DUE TO, OR AS A CONSEQUENCE OF (c): Triple Vessel coronary artery on autopsy 12/5/88

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [X] NO [ ] | YES [X] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE — DEGREE | ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN | 22c. DATE SIGNED |
|---|---|---|
| John Vitarello MD | [ ] [X] [ ] | 5Dec.1988 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): John A. Vitarello, MD | 22e. ADDRESS: 310 West Ninth St., Frederick, Md. 21701 | |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION — CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec.8,1988 | Rocky Springs Cemetery | Frederick, Frederick, MD |

| 24. FUNERAL DIRECTOR — NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Keeney & Basford P.A. Funeral Home, 106 East Church Street, Frederick, Md. 21701 | DEC 8 1988 | Julia Davidson-Randall |

017909 DEC -3 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 58 3672 6

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | |
|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | VIOLET / LORRAINE / CARTER |
| 2a. DATE OF DEATH MONTH DAY YEAR | 12 - 9 - 88 |
| 2b. HOUR | 0938 M |
| 3. SEX | F |
| 4. RACE | W |
| 5. DATE OF BIRTH MONTH DAY YEAR | 12 - 2 - 28 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 60 YRS |
| IF UNDER 1 YEAR MONTHS / DAYS | |
| IF UNDER 24 HRS HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | MARYLAND |
| 7b. CITIZEN OF WHAT COUNTRY? | U.S.A |
| 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | FREDERICK MD. |
| 10. CITY OR TOWN OF DEATH | FREDERICK |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | FREDERICK MEMORIAL |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | HOUSEWIFE |
| 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | MD |
| 13b. COUNTY | FREDERICK |
| 13c. CITY OR TOWN | FREDERICK |
| 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | |
| 13e. STREET ADDRESS | 9031 WORMANS MILL RD |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | QUINCY / LOWERY |
| 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | LENNIA / DEAN |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | NO |
| (IF YES, GIVE WAR OR DATES) | |
| 16b. SOCIAL SECURITY NO. | 212-24-6573 |
| 17. INFORMANT ADDRESS | JOHN M. CARTER FREDERICK, MD |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): COPD Pneumothorax

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE | Allen J. Gilson MD — DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED 12/9/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | ALLEN J. GILSON MD | 22e. ADDRESS 1475 TANEY AVE FRED MD |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE | 21701 |
| BURIAL | 12-12-88 | RESTHAVEN | FREDERICK / FRED / MD | |

| | | | |
|---|---|---|---|
| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| W.C. HILTON | BARNESVILLE, MD | DEC 16 1988 | Julia Davidson-Randall |

R BP 10

DHMH - 1650M 1/81 (VRA 15, 4)

017957 DEC-3 '88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36727 REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Lester | Leroy | Curfman | 12= 25 1988 | 2:45p M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
|---|---|---|---|---|---|
| Male | Caucasian | 2 13 1905 | 83 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | Frederick MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Frederick | Citizens Nursing Home | Farmer | dairy |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Frederick | Thurmont xxxxxxxxxxx | YES ☒ NO ☐ | 10810 Hessong Bridge Rd 21788 xxxxxxEdgemontxxRoadxx21788 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Frederick | Leroy | Curfman | Fannie | | Snyder |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | none | 220-30-9083 | Margaret Clabaugh | Thurmont, MD |

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Congestive heart failure | 2 years |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Coronary arteri-sclerosis | 10 years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I) (this hospital) attended the deceased from 8/4/83 19____ to 12/25/88 19____, that (I) (we) last saw the deceased alive on Dec. 24 19 88 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.

| 22b. SIGNATURE DEGREE | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|
| Bernard O. Thomas Jr. MD | | 12/26/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Bernard O. Thomas, Jr. | Professional Bldg. Frederick, MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Burial | 12/28/88 | Linganore Cemetery | Unionville Frederick MD |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| D. D. Hartzler | Libertytown, MD | DEC 30 1988 | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

BP_____

HMH - 16 60M 7/84
(VRA 15, 4)

0175317 LCC-300

Collection

016648 DEC 1988

1 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

REG. NO. 88 3672 3

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| ERNEST | CARL | DARFLER | NOVEMBER 28, 1988 | 7:25 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | JUNE 30 1921 | 67 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| NY | USA | MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | FREDERICK MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| FREDERICK | FREDERICK MEMORIAL HOSPITAL | MECHANIC | AIRLINES |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | MONTGOMERY | CLARKSBURG | YES ☐ NO ☒ | 2411 JENNIFER COURT |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| CARL | | DARFLER | MARY | | SPITZNER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| YES | WW II | 085-46-7286 | MARJORIE F. DARFLER | CLARKSBURG, MD 2411 JENNIFER COURT |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Heart failure | |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| (c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 11-28 19 83 to 11-28 19 88, that (I) (we) last saw the deceased alive on 11-28 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Kusum BARAKAT | 310 W. 8th Street Frederick MD 21701 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| CREMATION | 11/30/88 | RESTHAVEN MEM. GARDENS | FREDERICK / FREDERICK / MD |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| G. DOUGLAS STAUFFER 1621 Opossumtown Pike, Frederick, MD 21701 | DEC 1 1988 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 13

DHMH - 16 50M 1/81 (VRA 15, 4)

017917 DEC 1 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO. 036729

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: CHARLES | MIDDLE | LAST: DINTERMAN | 2a. DATE OF DEATH MONTH: NOV. DAY: 30 YEAR: 1988 | 2b. HOUR: 15:30 PM | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH: 02 DAY: 08 YEAR: 1913 | 6. AGE (IN YEARS LAST BIRTHDAY): 75 years YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick MD. | | |
| 10. CITY OR TOWN OF DEATH: Frederick | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Residence | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mechanic | 12b. KIND OF BUSINESS OR INDUSTRY: Town of Bruns. | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Frederick | Brunswick | YES ☒ NO ☐ | 704 East "F" St., Brunswick 21716 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Charles | Elmer | Dinterman | Lillian | May | Deterick |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 220105897 | Rachael M. Dinterman | 407 East "F" St. Brunswick, Md. 21716 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ACUTE MYO CARDIAC INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: instant

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): PARKINSON'S DISEASE

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from April 14, 19 83, to Nov 30, 19 88, that (I) (we) last saw the deceased alive on Nov. 14, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| L Kinland | MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 11-30-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| L KINLAND | 610 NINTH AVE, BRUNSWICK |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12/03/1988 | Park Heights Cemetery | Brunswick / Frederick / MD |

| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| John T. Williams Funeral Home | 100 Petersville Rd., Brunswick, Maryland 21716 | DEC 12 1988 | Julia Davidson-Randall |

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

016057 DEC 14 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 036730
REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Ruth | Elizabeth | DODSON | December 10, 1988 | 3:45 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Female | White | June 3, 1925 | 63 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | | Frederick County, MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Frederick | Frederick Memorial Hospital | Inventory Clerk | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Montgomery | Clarksburg | | 23635 Frederick Rd. 20871 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Vernon | | Dearstine | Eva | | Lilly |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 220-16-4451 | Scott F. Dodson, | Item 13 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Arteriosclerotic Cardiovascular disease | 10 years |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Diabetes Mellitus | 15 years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Colon carcinoma | 10 years |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19 63, to Dec. 10, 19 88, that (I) (we) last saw the deceased alive on Dec. 10, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| James P. Kerr M.D. | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | Dec.11, 1988 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| James P. Kerr, M.D. | 26618 Ridge Rd., Damascus, Md. 20872 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec.14,1988 | Parklawn | Rockville, Montgomery, Md. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Olin L. Molesworth, P.A., Damascus, Md. | DEC 13 1988 | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

015651 DEC 8 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified by law.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 036731

1. DECEASED NAME (TYPE OR PRINT): FIRST Joanna MIDDLE May LAST Doggett

2a. DATE OF DEATH: MONTH 12 DAY 2 YEAR 88

2b. HOUR 7 A.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH Sept. DAY 25 YEAR 1926

6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick MD.

10. CITY OR TOWN OF DEATH: Myersville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH A FACILITY, GIVE STREET ADDRESS): 10463-A Church Hill Road

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Teacher

12b. KIND OF BUSINESS OR INDUSTRY: Public School

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland 13b. COUNTY: Frederick 13c. CITY OR TOWN: Myersville 13d. INSIDE CITY LIMITS? YES [ ] NO [X] 13e. STREET ADDRESS / ZIP CODE: 10463-A Church Hill Road/21773

14. FATHER'S NAME: FIRST William MIDDLE E LAST Hauver

15. MOTHER'S MAIDEN NAME: FIRST Effie MIDDLE LAST Deter

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 216-40-8880

17. INFORMANT: Herbert L.D. Doggett ADDRESS: 10463-A Church Hill Road Myersville, MD 21773

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinoma of breast — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 9 years

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 3/24, 19 88, to 12/2, 19 88, that (I) (we) last saw the deceased alive on 11/21, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 12/2/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Frederick H. Kass III

22e. ADDRESS: 1825 Idwell Rd Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 12-2-88.

23c. NAME OF CEMETERY OR CREMATORY: Smithsburg Crematory

23d. LOCATION: CITY OR TOWN Smithsburg COUNTY Washington STATE Maryland

24. FUNERAL DIRECTOR: NAME Richett's Funeral ADDRESS Myersville, MD

25a. DATE REC'D. BY REGISTRAR: DEC 07 1988

25b. REGISTRAR'S SIGNATURE: Julia Dinden-Keefauver

017949 DEC 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36732
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

| 1. DECEASED NAME (TYPE OR PRINT) | FIRST | MIDDLE | LAST |
|---|---|---|---|
| | ALBERT | DANTON | ENSOR |

2a. DATE OF DEATH: MONTH DAY YEAR — Dec. 28, 1988
2b. HOUR: 7:30 P M

| 3. SEX | 4. RACE | 5. DATE OF BIRTH (MONTH DAY YEAR) | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 02/08/05 | 83 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | M | FREDERICK MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| NEW WINDSOR | 15228 OAK ORCHARD RD. | FARMER | DAIRY |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | FREDERICK | NEW WINDSOR | YES ☐ NO ☐ NO | 15228 OAK ORCHARD RD. 21776 |

| 14. FATHER'S NAME (FIRST MIDDLE LAST) | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) |
|---|---|
| SAMUEL ARMACOST ENSOR | MARGARET WOLFE |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | NONE | 215-22-4126 | MYRA F. ENSOR | 15228 OAK ORCHARD RD. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary heart disease — 1983
DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from April 25, 1983 to Nov 19 ____, that (I) (we) last saw the deceased alive on 12/5/88 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] Caricofe MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/28/88

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| J.H. CARICOFE | 104 N. MAIN ST. UNION BRIDGE, MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 01/02/89 | BETHEL CEMETERY | NR. NEW WINDSOR FRED. MD |

| 24. FUNERAL DIRECTOR (NAME) | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| D. D. HARTZLER | NEW WINDSOR, MD | DEC 30 1988 | [signature] |

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonapapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP ____

DHMH - 1650M 1/81 (VRA 15, 4)

017918 DEC-3109 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36733 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Beatrice | Middle: H. | Last: ETZLER | 2a. DATE OF DEATH Month/Day/Year: December 8, 1988 | 2b. HOUR: 4:30 P.M. | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH Month/Day/Year: March 4 1914 | 6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick County, MD. | | |
| 10. CITY OR TOWN OF DEATH: Frederick | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Meridian Nursing Home | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: - - - - | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Frederick | Frederick | YES ☐ NO ☒ | 7708 McKaig Rd. 21701 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last | |
|---|---|---|
| John Henry Lindwood Hyatt | Catherine C. Kelly | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | 16b. IF YES, GIVE WAR OR DATES: - - - - | 16b. SOCIAL SECURITY NO.: 219-07-5783 |
| 17. INFORMANT: Mr. George T. Horman | ADDRESS: 22 West 2nd St., Frederick, Maryland 21701 | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a): Cardiac Arrhythmia 2° Coronary Artery Disease — Approximate interval between onset and death: 3yrs.

DUE TO, OR AS A CONSEQUENCE OF (b): Diabetes Mellitus — 10yrs.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

* Fracture Left Tibia 8/3/88 (after fall)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 1986, 19____, to 12/8/88, 19____, that (I) (we) last saw the deceased alive on 11/7/88, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
|---|---|---|---|
| Robert L. Kaufmann | M.D. | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/8/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. Robert L. Kaufmann M.D. | 22e. ADDRESS: 300 West Ninth St., Frederick, Md. | | |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | 12/9/88 | Smithsburg Crematory | Smithsburg Wash. Md. |
| 24. FUNERAL DIRECTOR (NAME): Keeney & Basford P.A. Funeral Home, 106 East Church St., Frederick, Md. 21701 | | 25a. DATE REC'D. BY REGISTRAR: DEC 12 1988 | 25b. REGISTRAR'S SIGNATURE: Elaine Miller-Randall |

BP 4

DHMH - 1650M 1/81 (VRA 15, 4)

* Fwd. County Medical Examiner Notified 12/8/88

018672 JAN 10 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

B 8 3 6 7 3 4
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please mail the remaining papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other unusual circumstance, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Clara | MIDDLE: Edith | LAST: Flook | 2a. DATE OF DEATH MONTH DAY YEAR: 12-24-88 | 2b. HOUR: M | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: 9-20-1891 | 6. AGE (IN YEARS LAST BIRTHDAY): 97 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick MD. | | |
| 10. CITY OR TOWN OF DEATH: Frederick | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Homewood Retirement Center | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Frederick | 13c. CITY OR TOWN: Myersville | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS / ZIP CODE: Main Street/21773 | |
| 14. FATHER'S NAME FIRST: John | MIDDLE: C. | LAST: Leatherman | 15. MOTHER'S MAIDEN NAME FIRST: Susan | MIDDLE: Rebecca | LAST: Grossnickle |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 213-74-9905 | 17. INFORMANT: Dennis Flook | ADDRESS: Canada Hill Road Myersville, MD 21773 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Alzheimer's Disease

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from Many Years, 19____, to 12/24/88, 19____, that ~~I~~ (we) last saw the deceased alive on 12/24/88, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did not) view the body after death.

22b. SIGNATURE: A Austin Pearre Jr. DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/27/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): A. Austin Pearre, Jr. — 22e. ADDRESS: 300 W. 9th St., Frederick, Md 21701

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12-29-88 | 23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion U. Methodist | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Myersville Frederick Maryland |
| 24. FUNERAL DIRECTOR: Paul L Ricketts | ADDRESS: Ricketts Funeral Home Myersville, Maryland | 25a. DATE REC'D BY REGISTRAR: DEC 28 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

BP 4

DHMH - 16 60M 7/84
(VRA 15, 4)

016130 DEC 14 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 3673 5

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| GRANT | | GIBSON | 12/7/88 | 7:39 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | CAUCASIAN | Sept. 18, 1905 | 83 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| TENN. | USA | | FREDERICK CO. MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Frederick | FREDERICK MEM. HOSP | CARPENTER | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD. | CARROLL | MT. AIRY | YES ☐ NO ☑ | 6201 A Woodville Rd. 21771 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| HILEEY | | GIBSON | LOUISA | | Swiney |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | 226-18-6709A | GLESSYE M. NASH | WOODVILLE, MT. AIRY MD |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Respiratory arrest | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Bronchopneumonia, Congestive | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Heart failure, Chronic renal failure | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 10/25, 19 88, to 12/7, 19 88, that (I) (we) last saw the deceased alive on 12/6, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| John Vitarello | MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| JOHN VITARELLO | 335 PARK AVE. FREDERICK, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 12-1-88 | CRESTLAWN MEM. GARDN | MARRIOTTSVILLE HOWARD MD |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Harry W. Haight | Sykesville, Md | DEC 11 1988 | Julia Davidson-Landeau |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

018128 JAN -5 89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36736 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: RALPH MIDDLE: EDWARD LAST: GLADFELTER | | | 2a. DATE OF DEATH MONTH DAY YEAR: 12-29-88 | 2b. HOUR: 0514 M |
| 3. SEX: M | 4. RACE: W | 5. DATE OF BIRTH MONTH DAY YEAR: 4-12-33 | 6. AGE (IN YEARS LAST BIRTHDAY): 55 YRS | IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): ADAMS Co. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: FREDERICK Co. MD. | |
| 10. CITY OR TOWN OF DEATH: FREDERICK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FREDERICK MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SALES | 12b. KIND OF BUSINESS OR INDUSTRY: PRODUCE |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: PA | 13b. COUNTY: ADAMS | 13c. CITY OR TOWN: HANOVER | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET ADDRESS: 121 NARROW DRIVE |
| 14. FATHER'S NAME FIRST: LAVERE MIDDLE: LAST: GLADFELTER | | | 15. MOTHER'S MAIDEN NAME FIRST: RUTH MIDDLE: LAST: BOSSERMAN | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.: 185-28-1731 | 17. INFORMANT: GLADYS M. GLADFELTER ADDRESS: 121 NARROW DR, HANOVER, PA 17331 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIOPULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF (b): (R) Intracerebral Hemorrhage

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): DIABETIS MELLITUS, OBESITY, (L) Leg Thrombophlebitis IVC filter placed 12/1/88

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: 12/6/88 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: (R) Intracerebral hemorrhage | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE AUTOPSY FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/6 19 88 to 12/29 19 88, that (I) saw the deceased alive on 12/28 19 88, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did not) view the body after death.

22b. SIGNATURE: [signature] M.D. DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 12/29/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JAMES S. GRISSOM M.D.

22e. ADDRESS: 1475 TANEY AVE. Suite 204 FREDERICK, MD. 21701

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: 1-3-89 | 23c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET | 23d. LOCATION CITY OR TOWN: PENN TWP. COUNTY: YORK STATE: PA | |
| 24. FUNERAL DIRECTOR NAME: Guy M. Klinefelter ADDRESS: 549 CARLISLE ST., HANOVER PA | M00679 | 25a. DATE REC'D. BY REGISTRAR: JAN 3 1989 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall | |

BP

DHMH -16 50M 1/81 (VRA 15, 4)

017088 DEC 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 036737

2. DECEASED NAME (TYPE OR PRINT): First: Alton | Middle: Edwin | Last: Gosnell

2a. DATE OF DEATH: 12-19-88

2b. HOUR: 345 P M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: Sept. 18, 1904

6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS. IF UNDER 1 YEAR: MONTHS 3 DAYS 1. IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick Co., MD.

10. CITY OR TOWN OF DEATH: Frederick

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frederick Mem. Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): State Roads

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Howard

13c. CITY OR TOWN: Mt. Airy

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 1674 Florence Rd. 21771

14. FATHER'S NAME: First Basil | Middle W. | Last Gosnell

15. MOTHER'S MAIDEN NAME: First Katie | Middle A. | Last Cross

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

16b. (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 219-36-1114

17. INFORMANT ADDRESS: H. Kenneth Gosnell, Same as # 13

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiorespiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Respiratory Failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c): Emphysema

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Bronchitis, Hypertensive Heart Disease

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2):

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION: STREET | CITY OR TOWN | COUNTY | STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-19, 19 88, to 12-19, 19 88, that (I) (we) last saw the deceased alive on 12-19, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Carla D. Bowlan

DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12/20/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Barbara G. Mancia, M.D.

22e. ADDRESS: 11801 Elginwood Rd. Mount Airy MD 21701

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 12-22-1988

23c. NAME OF CEMETERY OR CREMATORY: Messiah Lutheran

23d. LOCATION: CITY OR TOWN | COUNTY: Carroll | STATE: Md.

24. FUNERAL DIRECTOR (NAME) | ADDRESS: Charles W. Burrier, Jr., Sykesville, Md.

25a. DATE REC'D. BY REGISTRAR: DEC 21 1988

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Reader

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

018663 JAN 10 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 036733

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward pages 1 and 2 to the local registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other unusual circumstances, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | MABEL / Kathryn / GREEN | 2a. DATE OF DEATH MONTH / DAY / YEAR | 12 / 27 / 88 | 2b. HOUR | M |
| 3. SEX | female | 4. RACE | white | 5. DATE OF BIRTH MONTH / DAY / YEAR | 05 / 05 / 1918 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 70 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS: HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Maryland | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Frederick MD. | | | | |
| 10. CITY OR TOWN OF DEATH | Frederick | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Frederick Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | housewife |
| 12b. KIND OF BUSINESS OR INDUSTRY | home | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Maryland | 13b. COUNTY | Frederick | 13c. CITY OR TOWN | Myersville |
| 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | | 13e. STREET ADDRESS | 10824 Pleasant Walk Road 21773 | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | Edgar / / Martin | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Lulu / Marker / Shepley | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | no | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | 220-16-0750 |
| 17. INFORMANT | Lester B. Green | ADDRESS | 1303 Penn Ave/Hagerstown | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 HOURS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) INFERIOR MYOCARDIAL INFARCTION — 48 HOURS

DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE — ≥2 YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: DIABETES MELLITUS

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) this hospital attended the deceased from 12/27 19 88 to 12/27 19 88, that (I) (we) last saw the deceased alive on 12/27 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN ☒ / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
| | MD | | 12-27-88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | JAMES L. ROESSLER MD | 22e. ADDRESS | PO BOX 17 MIDDLETOWN, MD. 21769 |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | burial | 23b. DATE | 12/31/88 | 23c. NAME OF CEMETERY OR CREMATORY: Mt Zion United Methodist |
| 23d. LOCATION CITY OR TOWN / COUNTY / STATE | Myersville / Frederick / MD | | | |
| 24. FUNERAL DIRECTOR NAME | Ricketts Funeral Home | ADDRESS | Myersville, Md 21773 | |
| 25a. DATE RECD. BY REGISTRAR | JAN 10 88 | 25b. REGISTRAR'S SIGNATURE | Julia Davidson-Randall | |

BP 3

DHMH - 1650M 1/81 (VRA 15, 4)

017963 DEC 3 89

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 367399

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT): First Leslie; Middle Walter; Last Grove Jr.

2a. DATE OF DEATH: Month December; Day 17; Year 1988

2b. HOUR: 3:50 PM

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: Month March 24, 1910

6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. If under 1 year: Months, Days. If under 24 hrs: Hours, Min.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick County, MD.

10. CITY OR TOWN OF DEATH: Frederick

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN ANY, GIVE STREET ADDRESS): Frederick Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Draftsman

12b. KIND OF BUSINESS OR INDUSTRY: Engineering Co.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Frederick

13c. CITY OR TOWN: Frederick

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 409 Biggs Ave., 21701

14. FATHER'S NAME: First Leslie; Middle W.; Last Grove, Sr.

15. MOTHER'S MAIDEN NAME: First Bertie; Middle May; Last Reisinger

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

16b. (IF YES, GIVE WAR OR DATES): None

16b. SOCIAL SECURITY NO.: 214-10-3840

17. INFORMANT: Ruth V. Grove

ADDRESS: 409 Biggs Avenue, Frederick, Md. 21701

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Terminal Metastatic Prostate cancer

DUE TO, OR AS A CONSEQUENCE OF

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from 8 19 88 to 12-17 19 88, that (I) (we) last saw the deceased alive on 12-17 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Arthur G. Manaco

DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 12/18/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ARTHUR G. MANACO, M.D.

22e. ADDRESS: 187 Thos Johnson Dr. Frederick MD 21701

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Dec. 20, 1988

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

23d. LOCATION: CITY OR TOWN: Frederick; COUNTY: Frederick; STATE: Md.

24. FUNERAL DIRECTOR: Keeney and Basford Funeral Home

ADDRESS: 106 East Church Street, Frederick, Md. 21701

25a. DATE REC'D. BY REGISTRAR: DEC 20 1988

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 10

OHMH - 1650M 1/81 (VRA 15, 4)

017913 DEC-388

FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

REG. NO. 88 36740

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Roy | Middle: Reuben | Last: Grove | 2a. DATE OF DEATH Month/Day/Year: DEC 14 1988 | 2b. HOUR: 1045A M | |
| 3. SEX: Male | 4. RACE: Caucasion | 5. DATE OF BIRTH Month/Day/Year: Sept. 9, 1906 | 6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS | # UNDER 1 YEAR: Months / Days | # UNDER 24 HRS: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick County, MD. | | |
| 10. CITY OR TOWN OF DEATH: Frederick | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frederick Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Station Manager | 12b. KIND OF BUSINESS OR INDUSTRY: Service/Gas | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Frederick | Frederick | YES [X] NO [ ] | 1318 North Market Street/21701 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last |
|---|---|
| Daniel / Reuben / Grove | Sarah / / Baker |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | 218-30-9393 | Mrs. Erma S. Grove, Frederick, Md. 21701 | 1318 N. Market Street |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) BLEEDING DUODENAL ULCER
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 11/25/88, 19__, to 12/14/88, 19__, that (I) (he) last saw the deceased alive on 12/14/88, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (he) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Gerald Wennan MD | ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 12/14/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| G. WENNAN | 1475 Taney Avenue, Frederick, Md. 21701 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec.17,1988 | Mount Olivet Cemetery | Frederick, Frederick, MD |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Keeney & Basford P.A. Funeral Home, 106 East Church Street, Frederick, Md. 21701 | DEC 15 1988 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81 (VRA 15, 4)

016646 DEC 1988

FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

88 REG. NO 36741

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| GRACE | RAMSBURG | HARLEY | December 4, 1988 | 1130 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
|---|---|---|---|---|---|
| Female | Caucasion | August 25, 1891 | 97 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | | Frederick County, MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Frederick | Frederick Memorial Hospital | Homemaker | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Frederick | Frederick | | 8909 Yellow Springs Road/21701 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Howard | Putman | Ramsburg | Mary | Elizabeth | Leatherman |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | |
|---|---|---|---|---|
| No | None | 218-30-7776 | Mrs. Kathleen Keefer | 8909 Yellow Springs Road, Frederick, Md. 21701 |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cerebrovascular accident | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Congestive Heart Failure | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Hypertension, Anemia

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (~~this hospital~~) attended the deceased from 11/23/88 19____ to 12/4/88 19____ that (I) (~~we~~) last saw the deceased alive on 12/4/88 19____, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Curtis Harris | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/5/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Dr. Austin A. Pearre, Jr., MD | 300 West Ninth Street, Frederick, MD. 21701 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec. 7, 1988 | Mount Olivet Cemetery | Frederick / Frederick / MD |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Keeney & Basford P.A. Funeral Home | 106 East Church Street, Frederick, MD. 21701 | DEC 5 1988 | Julia Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 3

DHMH - 1650M 1/81 (VRA 15, 4)

016603 DEC 19 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36742 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) — FIRST: Roman; MIDDLE: ; LAST: Harrant | 2a. DATE OF DEATH — MONTH: 12; DAY: 14; YEAR: 88 | 2b. HOUR: 4 35 P.M. | | |
| 3. SEX: M | 4. RACE: W | 5. DATE OF BIRTH — MONTH: 6; DAY: 10; YEAR: 19 | 6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS — IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WISCONSIN | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: FREDERICK COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH: FREDERICK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FREDERICK MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): | 12b. KIND OF BUSINESS OR INDUSTRY: | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD. | 13b. COUNTY: FREDERICK | 13c. CITY OR TOWN: FREDERICK | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13a. STREET ADDRESS: 418 Carroll Parkway 21701 |
| 14. FATHER'S NAME — FIRST: LOUIS; MIDDLE: ; LAST: HARRANT | 15. MOTHER'S MAIDEN NAME — FIRST: FRANCIS; MIDDLE: ; LAST: LINSMEYER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES): | 16b. SOCIAL SECURITY NO.: 366-16-2550 | 17. INFORMANT — ADDRESS: Betty Harrant-418 Carroll Parkway Frederick, Md. 21701 | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Malignant Ventricular Arrhythmia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Acute Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |

| | | |
|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION — STREET; CITY OR TOWN; COUNTY; STATE |

22a. I certify that (I) (this hospital) attended the deceased from 12/14 19 88 to 12/14 19 88, that (I) (we) last saw the deceased alive on 12/14 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Philip Shapiro | DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED: 12/14/88 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Philip Shapiro MD | 22e. ADDRESS: 814 Toll House Ave., Fred, Md 21701 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal | 23b. DATE: 12-14-88 | 23c. NAME OF CEMETERY OR CREMATORY: | 23d. LOCATION — CITY OR TOWN; COUNTY; STATE: | |
| 24. FUNERAL DIRECTOR — NAME: State Anatomy Board | ADDRESS: Balto., Md. | 25a. DATE REC'D BY REGISTRAR: DEC 16 1988 | 25b. REGISTRAR'S SIGNATURE: Jacqueline Davidson-Randall | |

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

016645 DEC 1988

1 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

58 36743
REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) First / Middle / Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|
| Charles Phillip Hiteshew, Jr | December 03 1988 | 0310 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
|---|---|---|---|---|---|
| Male | Caucasion | November 20, 1915 | 73 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | | Frederick County, MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Frederick | Frederick Memorial Hospital | Welder/Owner | Fabrication |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Frederick | Frederick | YES ☒ NO ☐ | 110 East Second Street/ 21701 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last |
|---|---|
| Charles P. Hiteshew | Ann S. Staley |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | None | 232-09-4131 | Mrs. Mary J. Hiteshew, 110 East Second Street Frederick, MD. 21701 |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| (IMMEDIATE CAUSE (a)) | Chronic Congestive Heart Failure | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Severe Arteriosclerotic Cardiovascular Disease | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Uremia

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from September, 19 88, to December, 19 88, that (I) (we) last saw the deceased alive on December 2, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| George I. Smith Jr. | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | 12/4/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| George I. Smith, Jr., MD | 300 W. Ninth Street, Frederick, Md. 21701 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec. 6, 1988 | Mount Olivet Cemetery | Frederick / Frederick, MD |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Keeney & Basford P.A. Funeral Home, 106 East Church Street, Frederick, MD. 21701 | DEC 5 1988 | Julia Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 20

DHMH - 1650M 1/81
(VRA 15, 4)

016636 DEC 19 88 - FOR STATE REGISTRAR

item#1 per FH film 648 2/2/89fj

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36744
REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Margaret Rutledge ~~Nettie~~ LAST: KENT | | | 2a. DATE OF DEATH MONTH DAY YEAR: December 7, 1988 | 2b. HOUR: 9:10 A.M. | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: March 20, 1915 | 6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): South Carolina | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick County MD. | | |
| 10. CITY OR TOWN OF DEATH: Ijamsville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 2909 Green Hill Court | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Home | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Frederick | Ijamsville | YES ☐ NO ☒ | 2909 Green Hill Ct., 21754 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Samuel M. Rutledge | Sally Hare |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | None | 262-03-6229 | Nelson Kent 2909 Green Hill Ct., Ijamsville, Md. 21754 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) prob pulmonary embolus

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

diffuse histiocytic lymphoma

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| None | | YES ☐ NO ☒ | YES ☐ NO ☒ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 10/87, 19__, to 12/7, 1988, that (I) (we) last saw the deceased alive on 12/1, 1988, and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/8/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Dr. P. Gregory Rausch | 4 West Seventh St., Frederick, Md. 21701 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12-13-1988 | Mountain View Mem. Pk. | Black Mountain, Buncombe N.C. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Keeney & Basford P.A. Funeral Home | 106 East Church St., Frederick, Md. 21701 | DEC 8 1988 | Julia Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 15

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO 88 36745

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: HOMER FREDERICK KINNA | | | 7a. DATE OF DEATH MONTH / DAY / YEAR: 12 / 9 / 88 | 7b. HOUR: 2109 M |
| 3. SEX: M | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH / DAY / YEAR: 08 / 04 / 05 | 6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: FREDERICK MD. | |
| 10. CITY OR TOWN OF DEATH: FREDERICK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FREDERICK MEMORIAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): MOVIE CAMERA TECHN | 12b. KIND OF BUSINESS OR INDUSTRY: |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD | 13b. COUNTY: MONTG | 13c. CITY OR TOWN: DICKERSON | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 16610 THURSTON RD 20842 |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST: HADD KINNA | | | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: MINNIE JOHNSON | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES | (IF YES, GIVE WAR OR DATES): WW II | 16b. SOCIAL SECURITY NO.: 577-14-6261 | 17. INFORMANT ADDRESS: EVELYN P. KINNA DICKERSON, MD. | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b): Rt femur fracture 2° auto accident
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): End Stage COPD, Peripheral Vascular disease

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DEC DAY 9 YEAR 1988 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2): automobile accident | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.): Street | 21f. LOCATION STREET: 118 CITY OR TOWN: Jefferson COUNTY: Frederick STATE: Md | |

22a. I certify that (I) (~~this hospital~~) attended the deceased from Dec 7 19 88 to Dec 9 19 88, that (I) (we) last saw the deceased alive on Dec 9 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Ted Hosler | DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12/10/88 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Lloyd Hosler MD | 22e. ADDRESS: 1475 Taney Ave, Frederick | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: 12/13/88 | 23c. NAME OF CEMETERY OR CREMATORY: HYATTSTOWN METHODIST | 23d. LOCATION CITY OR TOWN: HYATTSTOWN COUNTY: MONTG. STATE: MD |
| 24. FUNERAL DIRECTOR NAME: W.C. HILTON | ADDRESS: BARNESVILLE, MD | 25a. DATE REC'D. BY REGISTRAR: DEC 16 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Ferrell |

DHMH - 16 50M 1/81 (VRA 15, 4)

017922 DEC -3 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36746
REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: LAURA | MIDDLE: INGRAM | LAST: LEDFORD | 2a. DATE OF DEATH MONTH DAY YEAR: December 13, 1988 | 2b. HOUR: 8:53 PM | |
| 3. SEX: Female | 4. RACE: Caucasion | 5. DATE OF BIRTH MONTH DAY YEAR: June 26, 1918 | 6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick County, MD. | | |
| 10. CITY OR TOWN OF DEATH: Frederick | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frederick Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): House Parent | 12b. KIND OF BUSINESS OR INDUSTRY: Orphanage | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Frederick | Walkersville | YES ☒ NO ☐ | 37 Maple Avenue/ 21793 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Wilson / / Ingram | Venia / / Troutman |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | None | 245-70-5856 | Mrs. Marjorie Gouge, P.O. Box 64 Walkersville, Md21793 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF: (b) Congestive Heart failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF: (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic renal failure Diabetes

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 12-5, 19 88, to 12-13, 19 88, that (I) (we) last saw the deceased alive on 12-13, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE / DEGREE | 22c. DATE SIGNED |
|---|---|
| Gene F. Forke MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12-13-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Gene F. Forke MD | Coppermine Road, Woodsboro, Maryland 21798 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec.16,1988 | Troutman Cemetery | Bakersville, Mitchell, NC |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Keeney & Basford P.A. Funeral Home, 106 East Church Street, Frederick, Md. 21701 | DEC 14 1988 | Julia Davidson Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 1650M 1/81 (VRA 15, 4)

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FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 REG. NO. 36747

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Wallace | Parsons | LYNN | Nov. 24, 1988 | 10:50 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Male | White | April 11, 1901 | 87 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Washington D.C. | American | | Frederick MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Frederick | Meridian Nursing Center | Architect | U.S. Govmt. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Montg. | Silver Spring | YES ☐ NO ☒ | 7 Finsberry Court 20906 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| James | C. | Lynn | Mary | Ella | Sheriff |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | 578-32-2920 | Margaret M. Reed | 4303 Rolling Acres Mt. Airy, Md. Ct. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Congestive Heart Failure | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 11-19, 19 88, to 11-24, 19 88, that (I) (we) last saw the deceased on the above (I) (we) did (did not) view the body after death 11-23, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 11/25/1988 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Ronald E. Miller, M.D. | 4 Culwell Drive, Mt. Airy, Maryland 21771 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 11/28/88 | Columbia Gardens | Arlington, Virginia |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Olin L. Molesworth, P.A., | Damascus, Md. | NOV 29 1988 | |

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

TO FUNERAL DIRECTOR: After the burial-transit permit has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

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FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO 88 367488

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH | DAY | YEAR | 2b. HOUR |
| Mary | Agnes | Marchetti | Dec. | 29 | 1988 | 5:55 P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH | DAY | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS HOURS | MIN. |
|---|---|---|---|---|---|---|---|---|---|
| Female | White | Oct. | 14 | 1915 | 73 yrs. YRS | | | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Washington, DC | USA | | Frederick MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Ijamsville | 11413 Meadowland Drive | Housewife | own home |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Pr. Georges | W. Hyatts. | YES ☒ NO ☐ | 6415 24th. Place 20782 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Ciro | | Fioramonti | Catherine | | Nuzzi |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. (IF YES, GIVE WAR OR DATES) | SOCIAL SECURITY NO. | 17. INFORMANT (son-in-law) ADDRESS |
|---|---|---|---|
| N/A | N/A | 577-01-7861 | John Blanche (same as # 11) |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ovarian carcinoma with — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b) Abdominal carcinomatosis

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I) (this hospital) attended the deceased from Dec 1 19 88 to Dec 23 19 88, that (I) (we) last saw the deceased alive on Dec 23 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | 22c. DATE SIGNED |
|---|---|---|---|---|
| Junette Gibbons | MD | ATTENDING PHYSICIAN ☒ | MEDICAL DIRECTOR ☐ | STAFF PHYSICIAN ☐ | 12/29/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Junette C. Gibbons, MD | 1140 Varnum St. NE Suite 202 Wash., DC |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Burial | Jan. 3, 1989 | Ft. Lincoln Cemetery | Brentwood Pr. Georges Md. |

| 24. FUNERAL DIRECTOR (NAME) (ADDRESS) | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md. | JAN 5 1989 | Julia Davidson-Kendall |

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

16644 DEC 1988

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 367499 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 20

DHMH - 1650M 1/81 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Theresa | Middle: Trail | Last: MATHIAS | 2a. DATE OF DEATH Month Day Year: December 3, 1988 | 2b. HOUR: 6:00 A.M. | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH Month Day Year: May 27, 1896 | 6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick County, MD. | | |
| 10. CITY OR TOWN OF DEATH: Frederick | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frederick Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Home | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Frederick | Frederick | YES ☒ NO ☐ | 103 Council Street, 21701 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last |
|---|---|
| Charles / B. / Trail | Grace / / Winebrener |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | 219-36-4346 | E. Trail Mathias, | 221 West Layfette Ave., Baltimore, Md. 21217 |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hypertension - Cardiac Calcification

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from Many Yrs. 19____ to 12/3/88 19____, that (I) (we) last saw the deceased alive on 12/3/88 19____, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) ~~(did)~~ (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| A. Austin Pearre Jr. | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/5/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Dr. A. Austin Pearre, Jr., M.D. | 300 West Ninth Street, Frederick, Md. 21701 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec. 6, 1988 | Mt. Olivet Cemetery | Frederick, Frederick, Md. |

| 24. FUNERAL DIRECTOR NAME AND ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Robert C. Burgee Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701 | DEC 5 1988 | Julia Davidson-Randall |

017920 DEC -3

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO 88 36750

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH | DAY | YEAR | 2b. HOUR |
|---|---|---|---|---|---|---|
| GILCIN | FINLEY | MEADORS | 12 | 12 | 88 | 10 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH | DAY | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS HOURS | MIN. |
|---|---|---|---|---|---|---|---|---|---|
| M | W | 12 | 19 | 16 | 72 YRS | | | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARITAL STATUS | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| MS XXXXXXX XXXXXXX | USA | MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | FREDERICK CO. MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| FREDERICK | FREDERICK MEMORIAL HOSPITAL | PHYSICIAN | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | FREDERICK | WALKERSVILLE | YES ☐ NO ☒ | 8831 Whimsey Court 21793 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| GILCIN | FINLEY | MEADORS, SR | ELIZABETH | RHODA | PETTUS |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | N/A | 220-34-8827 | William T. Meadors | 7015 Ridge Rd., Frederick, MD |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | RUPTURED ABDOMINAL AORTIC ANEURYSM | 24 HR |
| DUE TO, OR AS A CONSEQUENCE OF (b) | HYPERTENSIVE HEART DISEASE | YEARS |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| ☐ | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 12-11 19 88 to 12-12 19 88 that (I) (we) last saw the deceased alive on 12-12 19 88 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN | 22c. DATE SIGNED |
|---|---|---|---|
| S Kahn | MD | ☒ ☐ ☐ | 12-12-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| S KAHAN MD | 4 W 7th ST |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| BURIAL | 12/14/88 | MT. OLIVET CEMETERY | FREDERICK | FREDERICK | MD |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| G. DOUGLAS STAUFFER, 1621 Opossumtown Pike, Frederick, MD 21701 | DEC 12 1988 | Julie Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 20

DHMH - 1650M 1/81 (VRA 15, 4)

016770 DEC 2088

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3675 1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST: RAY | MIDDLE: NMN | LAST: MOORE | 2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ MONTH: 12 DAY: 15 YEAR: 19 88 | 2b. HOUR: M | |
| 3. SEX: M | 4. RACE: CAU | 5. DATE OF BIRTH: MONTH 07 DAY 04 YEAR 20 | 6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS. | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN | 2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 15 YEAR 19 88 | 2d. HOUR: 0550 M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick MD. | | | | |
| 10. CITY OR TOWN OF DEATH: Frederick | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frederick Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Oiler- Crushed Stone Co. | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Frederick | 13c. CITY OR TOWN: Mt. Airy | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 14402 Black Ankle Rd. 21771 | | | |
| 14. FATHER'S NAME: FIRST Lloyd MIDDLE LAST Moore | 15. MOTHER'S MAIDEN NAME: FIRST Vinie MIDDLE LAST Collins | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 225-24-1473 | 17. INFORMANT: Mary E. Moore, Item 13 ADDRESS | | | | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIO PULMONARY ARREST

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☐ |
| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Robert R Roberts M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 12/15/88

EXAMINER'S NAME (TYPE OR PRINT): R R ROBERTS MD ADDRESS: 15 W 7th St Frederick Md 21701

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec. 19, 1988 | Lake View | Sykesville, Carroll, Md. |

24. FUNERAL DIRECTOR NAME / ADDRESS: Olin L. Molesworth, P.A., Damascus, Md.

25a. DATE REC'D. BY REGISTRAR: DEC 19 1988 25b. REGISTRAR'S SIGNATURE

BP

DHMH - 17
(VR A15 ME (5))

0019336 JAN 17 89

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR

REG. NO. 88 036752

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon paper, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, all other traumatic event, the medical examiner and the coroner or the

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Thomas | MIDDLE: H. | LAST: Monard | 2a. DATE OF DEATH MONTH: 12 | DAY: 26 | YEAR: 88 |
| 2b. HOUR: 17:37 PM | | | | | |
| 3. SEX: Male | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: April 20, 1918 | 6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick County, MD. | | |
| 10. CITY OR TOWN OF DEATH: Frederick | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frederick Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Superintendent | 12b. KIND OF BUSINESS OR INDUSTRY: Construction | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Montgomery | Rockville | YES ☒ NO ☐ | 1018 Scott Avenue / 20851 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Lewis | | Monard | Nettie | | Norwood |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| Yes | WWII | 218-09-5150 | Bonnie M. Monard, Wife, Same as #13 |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Acute Myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO OR AS A CONSEQUENCE OF (b): Atherosclerotic heart disease — 1975

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART IIa: Hypertension, old cerebrovascular accident

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| ☐ | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) this hospital) attended the deceased from Sept, 19 75, to present 19 88, that (I) (we) last saw the deceased alive on 10/25, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| John G. Lodmell | MD — ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/27/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| JOHN G. LODMELL, MD | 3801 Olney Sandy Spring Rd. Olney MD 20832 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | December 30, 1988 | Parklawn Memorial Park | Rockville / Maryland |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland | DEC 28 '88 | Julia Davidson-Randall |

BP 20+1

DHMH - 16 60M 7/84 (VRA 15, 4)

015981 DEC 13 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36753 REG. NO

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Dora (Dora Scott) | Middle: Scott (Scott) | Last: MULLINEAUX (Mullineaux) | 2a. DATE OF DEATH Month: 12 | Day: 7 | Year: 88 | 2b. HOUR: 4:50PM |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH Month: March Day: 12 Year: 1897 | 6. AGE (IN YEARS LAST BIRTHDAY): 91 YRS. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick County, MD. | | | |
| 10. CITY OR TOWN OF DEATH: Frederick | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frederick Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY | | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Carroll | Mt.Airy | YES ☒ NO ☐ | 203 Oak St. 21771 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Samuel | Norris | Scott | Margaret | Ellen | Burdette |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | | 215-03-6109 | Robert G. Callahan, Item 13 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Severe GI Bleeding.

DUE TO, OR AS A CONSEQUENCE OF (b): Etiol. undetermined

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 12-2 19 88, to 12-7 19 88, that (I) (we) last saw the deceased alive on 12-6 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| | MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12-7-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Ronald E. Miller, M.D. | 4 Culwell Dr., Mt. Airy, Md. 21771 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec.10,1988 | Howard Chapel | Long Corner, Howard, Md. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Olin L. Molesworth, P.A., Damascus, Md. | DEC 12 1988 | Julia Faidley Andrews |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

017919 DEC -3 88

FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

88 36754
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) James (James) | FIRST | Millard (Millard) | MIDDLE | Murphy (Murphy) | LAST |
| 2a. DATE OF DEATH | MONTH 12 | DAY 9 | YEAR 88 | 2b. HOUR 0655 AM | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: Sept. 22, 1937 | 6. AGE (IN YEARS LAST BIRTHDAY): 51 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick County MD. | | |
| 10. CITY OR TOWN OF DEATH: Frederick | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frederick Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Self Employed | 12b. KIND OF BUSINESS OR INDUSTRY: Plumber Cont. | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Frederick | Frederick | YES X NO ☐ | 1089 Rocky Springs rd., 21701 |

| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | |
|---|---|---|---|---|---|
| FIRST: Charles | MIDDLE: F. | LAST: Murphy | FIRST: Kathleen | MIDDLE | LAST: Barthlow |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | 214-34-7501 | Mrs. Sally G. Murphy | 1089 Rocky Springs Rd., Frederick, Md. 21701 XXX |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Bilateral pneumonia | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | extensive diffuse histiocytic lymphoma | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | 2 yrs | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO X | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 12/5 C 19__ to 12/7 19 88, that (I) (we) last saw the deceased alive on 12/3 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/9/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Dr. P. Gregory Rausch | 4 West Seventh Street, Frederick, 21701 Md. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12-12-1988 | Mt. Olivet Cemetery | Frederick, Frederick, Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Keeney & Basford P.A. Funeral Home | 106 East Church St., Frederick, Md. 21701 | DEC 12 1988 | |

BP 24

DHMH - 16 50M 1/81 (VRA 15, 4)

016642 DEC 10 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 36755

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| LILLIAN | MARGARET | MYERS | 12/4/88 | 2005 M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | CAUCASIAN | December 5, 1908 | 79 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | | Frederick MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Frederick | Frederick Memorial Hospital | Manager/Buyer | Dress Shop |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Frederick | Frederick | YES ☒ NO ☐ | 4 Fairview Avenue/ 21701 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| William | | ABB | Ella | | Lambert |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | IF YES, GIVE WAR OR DATES | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | None | 214-10-3879 | Mr. Charles Myers, 4 Fairview Avenue Frederick, Md. 21701 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CARDIOGENIC SHOCH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) | AORTIC Stenosis (SCUERE) | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 12/4, 19 88, to 12/4, 19 88, that (I) (we) last saw the deceased alive on ____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| John A. Vitarello MD | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | 4 Dec 1988 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| John A. Vitarello, M.D. | 310 West Ninth Street, Frederick, MD 21701 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec. 7, 1988 | Mount Olivet Cemetery | Frederick, Frederick, MD |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Md. 21701 | DEC 5 1988 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 6

DHMH - 1650M 1/81 (VRA 15, 4)

016649 DEC 19 81 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 : 36756 REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH | DAY | YEAR | 2b. HOUR |
|---|---|---|---|---|---|---|
| Larry | Richard | Naylor | 11 | 24 | 88 | 0811 M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH | DAY | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS HOURS | MIN. |
|---|---|---|---|---|---|---|---|---|---|
| MALE | BLACK | FEB. | 28 | 1948 | 40 YRS | | | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| MD | USA | | FREDERICK MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| FREDERICK | FREDERICK MEMORIAL HOSPITAL | UNEMPLOYED | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | FREDERICK | FREDERICK | YES ☒ NO ☐ | 138 W. All Saints St., 21701 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| ROGER | E. | NAYLOR, SR. | NAOMI | F. | BROWN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | N/A | 219-52-1133 | Naomi Naylor | Frederick, MD 62 Lincoln Apt., |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Aspiration pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular accident

DUE TO, OR AS A CONSEQUENCE OF (c) Chronic alcoholism

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): hepatic failure 2° cirrhosis hx. Kidney failure

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| NA | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (~~this hospital~~) attended the deceased from Nov 11, 19 88, to Nov 24, 19 88, that (I) (~~we~~) last saw the deceased alive on Nov 23, 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~ did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| R L Halverson | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 11/14/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Lloyd Halverson | 1475 Tony Ave, Frederick |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 11/28/88 | BARTONSVILLE CEMETERY | FREDERICK / FREDERICK / MD |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| G. DOUGLAS STAUFFER, 1621 Opossumtown Pike, Frederick, MD 21701 | DEC 1 1988 | Julia Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 2

DHMH - 16 50M 1/81 (VRA 15, 4)

015978 DEC 3 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36757
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: EDITH (DEATH) | MIDDLE: LEE | LAST: NORRIS (NORRIS) | 2a. DATE OF DEATH MONTH DAY YEAR: 12/08/88 | 2b. HOUR: 2 AM P | |
| 3. SEX: FEMALE F | 4. RACE: WHITE W | 5. DATE OF BIRTH MONTH DAY YEAR: 09/03/99 | 6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED W ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: FREDERICK MD. | | |
| 10. CITY OR TOWN OF DEATH: FREDERICK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS): FREDERICK MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE): HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD | 13b. COUNTY: FREDERICK | 13c. CITY OR TOWN: LIBERTYTOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET ADDRESS: 12123 MAIN ST. | 21762 |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST: GEORGE THOMAS | | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: IDA MAE MERCER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | 16b. IF YES, GIVE WAR OR DATES: NONE | 16b. SOCIAL SECURITY NO.: 212-74-3667 | 17. INFORMANT: MADELINE N. WHIPP | ADDRESS: 8500 MAPLEVILLE RD. MT. AIRY, MD | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebrovasc. Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 WKS

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐ (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 1985 to 12/8/88, that (I) (we) last saw the deceased alive on 12/8/88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (Coroner) (did not) view the body after death.

22b. SIGNATURE: Robert L. Kaufmann, M.D. — DEGREE: ATTENDING PHYSICIAN X ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/8/88

| | |
|---|---|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): ROBERT L. KAUFMANN | 22e. ADDRESS: 300 W. 9th ST. FREDERICK, MD |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: 12/10/88 | 23c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEMETERY | 23d. LOCATION CITY OR TOWN: FREDERICK / COUNTY: FRED. / STATE: MD | |
| 24. FUNERAL DIRECTOR NAME: D. D. HARTZLER | ADDRESS: LIBERTYTOWN, MD | 25a. DATE REC'D. BY REGISTRAR: DEC 12 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davison-Landers | |

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

015381 DEC-6 88 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36753 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Donald / DONALD | Middle: Eugene / EUGENE | Last: NORWOOD, Sr. / NORWOOD Sr | 2a. DATE OF DEATH Month Day Year: December 1, 1988 | 2b. HOUR: 4:40PM | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH Month Day Year: April 16, 1931 | 6. AGE (IN YEARS LAST BIRTHDAY): 57 YRS | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: American | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick County MD. | | |
| 10. CITY OR TOWN OF DEATH: Frederick | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frederick Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Carpenter | 12b. KIND OF BUSINESS OR INDUSTRY: | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Frederick | 13c. CITY OR TOWN: Mt. Airy | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 702 South Main Street | 21771 |
| 14. FATHER'S NAME First Middle Last: Charles Kemp Norwood, Sr. | | | 15. MOTHER'S MAIDEN NAME First Middle Last: Hattie Rimbey | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes | (IF YES, GIVE WAR OR DATES): Viet Namm | 16b. SOCIAL SECURITY NO.: 220-26-7418 | 17. INFORMANT: Dorothy M. Norwood | ADDRESS: Item#13 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Terminal Metastatic Pancreatic Cancer

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 11-15, 1988 to 12-1, 1988, that (I) (we) last saw the deceased alive on 12-1, 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: Arthur G. Norwood | DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12/21/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): ARTHUR G. NORWOOD, MD | 22e. ADDRESS: 187 Thomas Johnson Dr. Frederick MD 21701 | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/04/88 | 23c. NAME OF CEMETERY OR CREMATORY: Pine Grove Ceme. | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Mt. Airy Carroll Md. | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: Olin L. Molesworth, P.A., Damascus, Md. | DEATH REC'D. BY REGISTRAR: DEC 5 - 1988 | 25. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

DHMH - 1650M 1/81 (VRA 15, 4)

Maryland American Frederick County

Frederick Frederick Memorial Hospital Carpenter

Maryland Frederick Rt. Alex x 702 South Main Street

Charles Kenn Norwood, Sr. Battle Bishop

Tex Vlet Kamm 220-16-7418 Dorothy M. Norwood Item[1]

018101 JAN -5 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

REG. NO. 88 36759

1. DECEASED NAME (TYPE OR PRINT): FIRST GRACE; MIDDLE ELIZABETH; LAST NUSBAUM
2a. DATE OF DEATH: MONTH 12/ DAY 21/ YEAR 88
2b. HOUR: 4:00AM
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: MONTH 01/ DAY 28/ YEAR 04
6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS.
IF UNDER 1 YEAR: MONTHS; DAYS
IF UNDER 24 HRS.: HOURS; MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ W DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: FREDERICK MD.
10. CITY OR TOWN OF DEATH: FREDERICK
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 6024 LINGANORE RD.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE
12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: CARROLL
13c. CITY OR TOWN: TANEYTOWN
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 6024 BAPTIST RD. 21787

14. FATHER'S NAME: FIRST JESSIE; MIDDLE WARNER; LAST
15. MOTHER'S MAIDEN NAME: FIRST ELIZABETH; MIDDLE HIVELY; LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
16b. SOCIAL SECURITY NO.: 217-09-4481
17. INFORMANT: MAXINE WATKINS ADDRESS: 6024 LINGANORE RD.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Adenocarcinoma of Ovary
DUE TO, OR AS A CONSEQUENCE OF (b): Hypertension
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Pulmonary Emboli Nov. 88

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (~~saw the hospital~~) attended the deceased from July 3, 19 83, to 12/21 19 88, that (I) (we) last saw the deceased alive on 12/20 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.
22b. SIGNATURE: James S. Grisson M.D.
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/21/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): JAMES S. GRISSOM M.D.
22e. ADDRESS: 1475 TANEY AVE SUITE 204 FREDERICK MD. 21701

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: 12/23/88
23c. NAME OF CEMETERY OR CREMATORY: BAUST CEMETERY
23d. LOCATION CITY OR TOWN: TYRONE; COUNTY: CARROLL; STATE: MD
24. FUNERAL DIRECTOR NAME: D. D. HARTZLER NEW WINDSOR, MD
25a. DATE REC'D. BY REGISTRAR: DEC 23 '88
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

017965 DEC 3 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 : 36760 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: VIRGINIA | Middle: FRANCIS | Last: POOLE | 2a. DATE OF DEATH Month: 12 Day: 17 Year: 88 | 2b. HOUR 5:30 PM | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH Month: 5 Day: 26 Year: 29 | 6. AGE (IN YEARS LAST BIRTHDAY): 59 YRS | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick County, MD. | | |
| 10. CITY OR TOWN OF DEATH: Frederick | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frederick Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Home | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Frederick | Frederick | YES ☐ NO XX | 2817 Thurston Road, 21701 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last |
|---|---|
| James Walter Eugene Cook | Della Ann Neel |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | 214-28-4122 | John O. Poole, | 2817 Thurston Road Frederick, Md. 21701 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Sudden Cardiac death | 6 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Pulmonary edema | 6 days |
| DUE TO, OR AS A CONSEQUENCE OF (c) | hypertension | years |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): diabetes mellitus insufficiency

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) this hospital) attended the deceased from 12-11 19 88, to 12-17 19 88, that (I) (we) last saw the deceased alive on 12-17 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | 22c. DATE SIGNED |
|---|---|---|---|---|
| S Kal | MD | ATTENDING PHYSICIAN ☒ | MEDICAL DIRECTOR ☐ | STAFF PHYSICIAN ☐ | 12-17-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| S KAHAN MD | 4 W 7th ST |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec. 21, 1988 | Resthaven Mem. Gardens | Frederick / Frederick, Md. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Md. 21701 | DEC 20 1988 | Julia Davidson-Randall |

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

017964

STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 036761

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP 3

DHMH - 16 50M 1/81 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: STELLA | MIDDLE: MAY | LAST: PORTEUS | 2a. DATE OF DEATH MONTH: 12 | DAY: 16 | YEAR: 88 | 2b. HOUR: 8 PM |
| 3. SEX: Female | 4. RACE: CAUCASIAN | 5. DATE OF BIRTH MONTH: 5 | DAY: 27 | YEAR: 10 | 6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick County, MD. | | | |
| 10. CITY OR TOWN OF DEATH: Frederick | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frederick Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Maid | 12b. KIND OF BUSINESS OR INDUSTRY: Motel | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Frederick | 13c. CITY OR TOWN: Frederick | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 3 Locust Street, 21701 | | |
| 14. FATHER'S NAME FIRST: Benjamin | MIDDLE | LAST: Mossburg | 15. MOTHER'S MAIDEN NAME FIRST: Fannie | MIDDLE | LAST: Burdette | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): None | 16b. SOCIAL SECURITY NO.: 215-36-6639 | 17. INFORMANT ADDRESS: 3 Locust Street | William Wayne Porteus, Frederick, Md. 21701 | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIAC TAMPONADE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: INSTANT

DUE TO, OR AS A CONSEQUENCE OF (b): INFERIOR MI — 2 DAYS

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: COPD

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12-14 19 88 to 12-16 19 88, that (I) (we) last saw the deceased alive on 12-16 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: S Kahan | DEGREE: MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12/16/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): S KAHAN MD | 22e. ADDRESS: 1 W 7th St | | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Dec. 20, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: Frederick Memorial Park | 23d. LOCATION CITY OR TOWN: Frederick / COUNTY: Frederick / STATE: Md. |
| 24. FUNERAL DIRECTOR NAME AND ADDRESS: Keeney & Basford P.A. Funeral Home, 106 East Church Street, Frederick, Md. 21701 | 25a. DATE REC'D BY REGISTRAR: DEC 20 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Kimball | |

017914 DEC -3 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO. 36762

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) — FIRST: PETER — MIDDLE: PAUL — LAST: PROZIALECK
2a. DATE OF DEATH — MONTH: 12 — DAY: 7 — YEAR: 88
2b. HOUR: 0945 M
3. SEX: M
4. RACE: W
5. DATE OF BIRTH — MONTH: 8 — DAY: 13 — YEAR: 18
6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NJ
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: FREDERICK MD.
10. CITY OR TOWN OF DEATH: FREDERICK
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FREDERICK MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): STEELWORKER
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: FREDERICK
13c. CITY OR TOWN: FREDERICK
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS: 6901 CHOKEBERRY COURT 21701

14. FATHER'S NAME — FIRST: PETER — MIDDLE: PAUL — LAST: PROZIALECK, SR.
15. MOTHER'S MAIDEN NAME — FIRST: CHRISTINA — MIDDLE: — LAST: (UNKNOWN)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES
16b. (IF YES, GIVE WAR OR DATES): WW II
16b. SOCIAL SECURITY NO.: 209-01-3498
17. INFORMANT: PAUL M. PROZIALECK — ADDRESS: 18720 PAPRIKA CT., GERMANTOWN, MD

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | UREMIA | 48hr |
| DUE TO, OR AS A CONSEQUENCE OF (b) | CHRONIC RENAL FAILURE | 4yr |
| DUE TO, OR AS A CONSEQUENCE OF (c) | AMYLOIDOSIS | 4yr |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): PERIPHERAL VASCULAR DISEASE, CONGESTIVE HEART FAILURE

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]
21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) ~~(the hospital)~~ attended the deceased from 3/5 19 86, to 12/7 19 88, that (I) (~~was~~) last saw the deceased alive on 12/6 19 88, and that in (my) (~~the~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~was~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: Mark P. Rubin — DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 12/7/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): MARK P. RUBIN
22e. ADDRESS: 56 Thomas Johnson Dr. Frederick MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: 12/10/88
23c. NAME OF CEMETERY OR CREMATORY: ST. PETER&PAUL CEMETERY
23d. LOCATION — CITY OR TOWN: DUNLO — COUNTY: CAMBRIA — STATE: PA
24. FUNERAL DIRECTOR NAME: G. DOUGLAS STAUFFER — ADDRESS: 1621 Opossumtown Pike, Frederick MD 21701
25a. DATE REC'D. BY REGISTRAR: DEC 12 1988
25b. REGISTRAR'S SIGNATURE: Trisha Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 7

DHMH - 16 50M 1/81 (VRA 15, 4)

017912 DEC-3189

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 3676

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Frances | Middle: Williams | Last: Ross | 2a. DATE OF DEATH Month Day Year: December 15, 1988 | 2b. HOUR: 12:40 P.M. | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH Month Day Year: April 7, 1909 | 6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington D. C. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick County, MD. | | |
| 10. CITY OR TOWN OF DEATH: Ijamsville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 9410 Reich's Ford Road | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Registered Nurse | 12b. KIND OF BUSINESS OR INDUSTRY: Nursing | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Frederick | 13c. CITY OR TOWN: Ijamsville | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 9410-A Reich's Ford Road, 21754 | |
| 14. FATHER'S NAME First: Charles | Middle: Richard | Last: Williams | 15. MOTHER'S MAIDEN NAME First: Jennie | Middle: | Last: Spencer |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): None | 16b. SOCIAL SECURITY NO.: 217-34-0725 | 17. INFORMANT: Mrs. S. Michael Thomas, Rd., | ADDRESS: 9410-A Reich's Ford Ijamsville, Md. | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 mins

DUE TO, OR AS A CONSEQUENCE OF (b): Acute stroke CA Colon — 2yrs

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Timothy Hickey Jr. DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. Timothy Hickey, Jr., M.D. — 22e. ADDRESS: Parkview Medical Center, Frederick, Md.

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation | 23b. DATE: Dec 15, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: Smithsburg Crematory | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Smithsburg, Washington, Md. |
| 24. FUNERAL DIRECTOR NAME: Feeney and Basford Funeral Home | ADDRESS: 106 East Church Street, Frederick, Md. 21701 | 25a. DATE REC'D BY REGISTRAR: DEC 15 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH - 16 50M 1/81 (VRA 15, 4)

017906 DEC-3189

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 036764

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Eleanor | Middle: Marie | Last: Shepley | 2a. DATE OF DEATH Month: December Day: 15, Year: 1988 | 2b. HOUR 2:30 P.M. | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH Month: Dec. Day: 8, Year: 1925 | 6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick County, MD. | | |
| 10. CITY OR TOWN OF DEATH: Frederick | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frederick Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Cafeteria worker | 12b. KIND OF BUSINESS OR INDUSTRY: U.S. Government | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Frederick | 13c. CITY OR TOWN: Frederick | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 521 Bentz Street, 21701 | |
| 14. FATHER'S NAME First: William Middle: Last: Riordan | | 15. MOTHER'S MAIDEN NAME First: Joanna Middle: Last: Morrisey | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): None | 16b. SOCIAL SECURITY NO.: 220-16-1992 | 17. INFORMANT: Allan L. Perkins, | ADDRESS: 231 East Fourth Street Frederick, Md. 21701 | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): PROBABLE MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF

(c): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): hypertension

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from JANUARY 31, 19 88, to DEC 15, 19 88, that (I) (we) last saw the deceased alive on DEC 15, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: George I. Smith | DEGREE: M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12/16/88 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. George I. Smith, Jr., M.D. | 22e. ADDRESS: 300 West Ninth Street, Frederick, Md. 21701 | | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Dec. 19, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: Resthaven Memorial Gardens | 23d. LOCATION CITY OR TOWN: Frederick, COUNTY: Fred., STATE: Md. |
| 24. FUNERAL DIRECTOR NAME: Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701 | | 25a. DATE REC'D. BY REGISTRAR: DEC 19 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

BP 1

DHMH - 16 50M 1/81 (VRA 15, 4)

017916 DEC 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

B 8 REG. NO. 36765

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Helen | MIDDLE: Mae | LAST: Shoemaker | 2a. DATE OF DEATH MONTH: 12 | DAY: 9 | YEAR: 88 | 2b. HOUR: 5:45 AM |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH: 7 | DAY: 4 | YEAR: 10 | 6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. | IF UNDER 1 YEAR MONTHS / DAYS; IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | | | 9. BALTIMORE CITY OR COUNTY OF DEATH: FREDERICK MD. | |
| 10. CITY OR TOWN OF DEATH: MT. AIRY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PLEASANT VIEW NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ASSEMBLY WORKER | 12b. KIND OF BUSINESS OR INDUSTRY |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MD | FREDERICK | FREDERICK | YES ☐ NO ☒ | 10304 LIBERTY ROAD, 21701 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| CALVIN | D.H. | SUMMERS | BESSIE | | HARSHMAN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | N/A | 220-09-7078 | CLARENCE T. SHOEMAKER | FREDERICK, MD 10304 LIBERTY RD. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiorespiratory Arrest | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Hypertensive Atherosclerotic Cardiovascular Disease | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes Mellitus, Senility

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 11-4, 19 88, to 12-9, 19 88, that (I) (we) last saw the deceased alive on 11-28, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Arthur G. Norman | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/9/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Arthur G. Norman, M.D. | 187 Thomas Johnson Dr. Frederick, MD 21701 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 12/12/88 | ST. PAUL'S CEMETERY | PT. OF ROCKS FREDERICK MD |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| G. DOUGLAS STAUFFER 1621 Opossumtown Pike, Frederick, MD 21701 | DEC 12 1988 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 93

DHMH - 16 60M 7/84 (VRA 15, 4)

013533 DEC 28 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO. 36766

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 27 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: MARY (Mary) MIDDLE: W. (W.) LAST: SIGMAN (SIGMAN) | | | 2a. DATE OF DEATH MONTH DAY YEAR: DECEMBER 9, 1988 | 2b. HOUR: 5:45 PM |
| 3. SEX: female | 4. RACE: white | 5. DATE OF BIRTH MONTH DAY YEAR: Feb. 26, 1891 | 6. AGE (IN YEARS LAST BIRTHDAY): 97 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick MD. | |
| 10. CITY OR TOWN OF DEATH: Frederick | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Homewood Retirement Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Home |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: D.C. | 13b. COUNTY | 13c. CITY OR TOWN: Washington | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS / ZIP CODE: 2100 Connecticut Ave. N.W. 20008 |
| 14. FATHER'S NAME FIRST: Thomas MIDDLE: LAST: Sigman | | | 15. MOTHER'S MAIDEN NAME FIRST: Susan MIDDLE: LAST: Cassler | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES): | 16b. SOCIAL SECURITY NO.: 577-07-3614 | | 17. INFORMANT: T. William Blumenauer Jr. | ADDRESS: Bethesda, Md. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ARTERIOSCLEROTIC CARDIO-VASCULAR disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: G.E. Glaucoma ? underlying malignancy

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 5/10, 19 88, to 12/9, 19 88, that (I) (we) last saw the deceased alive on 12/9, 19 88, and that in (my) (our opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Gene L. Smith M.D. DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/10/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): — 22e. ADDRESS:

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation | 23b. DATE: Dec. 12, 88 | 23c. NAME OF CEMETERY OR CREMATORY: Smithsburg Crematory | 23d. LOCATION CITY OR TOWN: Smithsburg, COUNTY: Wash, STATE: Md. | |
| 24. FUNERAL DIRECTOR NAME: Davis Funeral Home | Dennis L. Davis Smithsburg, Md. | 25a. DATE REC'D. BY REGISTRAR: DEC 15 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH - 16 60M 7/84 (VRA 15, 4)

016443 DEC 15 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO. 36767

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: DAVID | MIDDLE: RUFUS | LAST: STONER, SR. | 2a. DATE OF DEATH MONTH DAY YEAR: Dec 12/10/88 | 2b. HOUR: 9A M | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR: 02/23/93 | 6. AGE (IN YEARS LAST BIRTHDAY): 95 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: FREDERICK MD. | | |
| 10. CITY OR TOWN OF DEATH: WOODSBORO | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 11456 KEYMAR RD. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): FARMER | 12b. KIND OF BUSINESS OR INDUSTRY: AGRICULTURE | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
|---|---|---|---|---|---|
| MD | FREDERICK | WOODSBORO | YES ☐ NO ☐ | 11456 KEYMAR RD. | 21798 |

| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |
|---|---|
| EZRA STONER | ELIZABETH FUSS |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | NONE | 218-32-3545 | DAVID R. STONER, JR. | 11456 KEYMAR RD. |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Ischemic heart disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (~~this hospital~~) attended the deceased from Jan 5, 19 62, to NOW, 19 ____, that (I) (we) last saw the deceased alive on 10/27/88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: D.H. Caricofe M.D. — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/10/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): D.H. CARICOFE M.D. — 22e. ADDRESS: P.O. Box M, Union Bridge, Md. 21791

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / STATE |
|---|---|---|---|
| BURIAL | 12/13/88 | PIPE CREEK CEMETERY | NR. NEW WINDSOR / CARROLL / MD |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| D.B. HARTZLER | UNION BRIDGE, MD | DEC 14 1988 | |

BP____

DHMH - 16 50M 1/81 (VRA 15, 4)

016641 DEC 1988

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 367689 REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Helen | Jackson | Strosnider | December 01 1988 | 0550 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
|---|---|---|---|---|---|
| F | W. | JAN. 1 1921 | 67 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| VA | USA | | FREDERICK MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| FREDERICK | FREDERICK MEMORIAL HOSPITAL | SALES MNGR. | RETAIL |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | FREDERICK | WALKERSVILLE | YES ☒ NO ☐ | 82 SHERWOOD DR., 21793 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| RALEIGH | | JACKSON | JULIA | | ADAMS |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | N/A | 228-05-3936-A | Charles L. Strosnider | Walkersville, MD 82 Sherwood Dr. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bronchogenic (Epidermoid) Carcinoma of Lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 18 mos

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 5/88 19 to 12/1/88 19, that (I) (we) last saw the deceased alive on 12/1/88 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Robert L. Kaufmann MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/1/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| ROBERT L. KAUFMANN, MD | 300 W. 9th St., Frederick, MD 21701 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 12/4/88 | RESTHAVEN MEM. GARDENS | FREDERICK FREDERICK MD |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| G. DOUGLAS STAUFFER | 1621 Opossumtown Pike, Frederick, MD 21701 | DEC 5 1988 | Julia Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 6+4

DHMH - 16 50M 1/81 (VRA 15, 4)

0167120 DEC 88

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR USE ONLY — REG NO. 3 3 6 7 6 9

1. DECEASED NAME (TYPE OR PRINT): FIRST JAMES MIDDLE Maurice LAST Thomas

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 12 DAY 07 YEAR 1988 — 2b. HOUR

3. SEX: M — 4. RACE: N 2 — 5. DATE OF BIRTH: MONTH 08 DAY 27 YEAR 13 — 6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 07 YEAR 1988 — 2d. HOUR 1100 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A

8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick MD.

10. CITY OR TOWN OF DEATH: Frederick — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 403A West South — 12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Retired U.S. Govt. — 12b. KIND OF BUSINESS OR INDUSTRY

RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md — 13b. COUNTY: Fred — 13c. CITY OR TOWN: Fred — 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS: 21201 403A West St.

14. FATHER'S NAME: FIRST JAMES MIDDLE LAST THOMAS

15. MOTHER'S MAIDEN NAME: FIRST LOVIA MIDDLE LAST KING

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES — IF YES, GIVE WAR OR DATES: W.W. II — 16b. SOCIAL SECURITY NO.: 217-05-0886 — 17. INFORMANT: Patsy Collins-Same As — ADDRESS: 13E

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIO PULMONARY ARREST

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X] and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Robt R R Roberts M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 12/07/88

EXAMINER'S NAME (TYPE OR PRINT): R R Roberts MD — ADDRESS: 15 W 7th Street Frederick Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: 12-10-88 — 23c. NAME OF CEMETERY OR CREMATORY: FAIRVIEW — 23d. LOCATION CITY OR TOWN: Fred, COUNTY: Fred. STATE: Md.

24. FUNERAL DIRECTOR NAME: C.E. Hicks III — ADDRESS: Annapolis-Md

25a. DATE REC'D. BY REGISTRAR: DEC 15 1988 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 5. PAGE 5 IS FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

017905 DEC 1-3 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3770

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH / ESTIMATED | MONTH | DAY | YEAR | 2b. HOUR |
| RUSSELL | GALEN | Thrasher | ESTIMATED | 12 | 16 | 19 88 | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN | 2c. DATE PRONOUNCED DEAD | 2d. HOUR |
| Male | CAU | 05 08 51 | 37 YRS. | | | 12 16 19 88 | 0830 M |

| | | | | |
|---|---|---|---|---|
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Kansas | U.S.A. | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | Frederick County, | MD |

| | | | |
|---|---|---|---|
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| Frederick | 318 East Third Street | Technician | Electronics |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES / NO | 13e. STREET ADDRESS |
| Maryland | Frederick | Frederick | YES [X] NO [ ] | 318 East Third St., 21701 |

| | | | | |
|---|---|---|---|---|
| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE / LAST |
| Benjamin | | Thrasher | Anita | Mae Pitts |

| | | | |
|---|---|---|---|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
| No | None | 585-26-4240 | Kathryn Thrasher, 1116 H Taney Apartments Frederick, Md. 21701 |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CARDIOPULMONARY ARREST | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost — DUE TO, OR AS A CONSEQUENCE OF (b) | Chronic ALCOHOLISM | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES / NO |
| | | YES [ ] NO [X] |

| | | |
|---|---|---|
| 21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE Robert R Roberts M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 12/16/88

EXAMINER'S NAME (TYPE OR PRINT) RRR ROBERTS MD ADDRESS 15 W 7TH ST Frederick Md 21701-4599

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
| Burial | Dec. 19, 1988 | Resthaven Memorial Gardens | Frederick, Frederick, Md. |

| | | |
|---|---|---|
| 24. FUNERAL DIRECTOR NAME | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701 | DEC 19 1988 | Julia Davidson-Randall |

07/84 25M BP 10

DHMH - 17 (VR A15 ME (5))

016639 DEC 1988

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36771

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

| 1. DECEASED NAME (TYPE OR PRINT) | FIRST | MIDDLE | LAST |
|---|---|---|---|
| | IRENE | VIOLA | TOMLIN |

| 2a. DATE OF DEATH | KNOWN ☒ / ESTIMATED ☐ | MONTH | DAY | YEAR | 2b. HOUR |
|---|---|---|---|---|---|
| | | 12 | 03 | 19 88 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH | DAY | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|---|---|
| F | CAU | 12 | 29 | 20 | 68 YRS. | | | | |

| 2c. DATE PRONOUNCED DEAD | MONTH | DAY | YEAR | 2d. HOUR |
|---|---|---|---|---|
| | 12 | 03 | 19 88 | 1435 M |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | | Frederick MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Frederick | 303 Catoctin Avenue | None | None |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Frederick | Frederick | YES XX NO ☐ | 303 Catoctin Avenue/21701 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Lewis | Daniel | Tomlin | Phoefe | Mae | Erdenbrecht |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 213-60-8216 | Mr. Richard M. Boyd | 303 Catoctin Avenue Frederick, Md. 21701 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CARDIOPULMONARY ARREST | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. — DUE TO, OR AS A CONSEQUENCE OF (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO XX |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Robert R Roberts M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 12/03/88

EXAMINER'S NAME (TYPE OR PRINT) R R ROBERTS MD ADDRESS 15 W 7th St Frederick Md 21701

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Cremation | 12-5-1988 | Smithsburg Crematory | Smithsburg, | Washington, | Md. |

| FUNERAL DIRECTOR | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| R.E. DAILEY & SON, P.A. | 1201 N. Market Street Frederick, Md. 21701 | DEC 8 1988 | Julia M. Moore Pindell |

07/84 25M BP 3

DHMH - 17 (VR A15 ME (5))

Item #4 Film G647 1/13/89 cj

0

019358 JAN 17

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

88 36772 REG. NO.

1a. DECEASED NAME (TYPE OR PRINT) — FIRST: AMANDA — MIDDLE: Edmonia — LAST: WEEDON

2a. DATE OF DEATH — MONTH: Dec — DAY: 5 — YEAR: 1988

2b. HOUR: 830 A M

3. SEX: Female

4. RACE: ~~White~~ Negro

5. DATE OF BIRTH — MONTH: 05 — DAY: 13 — YEAR: 1912

6. AGE (IN YEARS LAST BIRTHDAY): 76 years YRS — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Knoxville, MD

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick MD.

10. CITY OR TOWN OF DEATH: Frederick

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Residence

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: Homemaker

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Frederick

13c. CITY OR TOWN: Frederick

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS: 4527 Mountville Road 21701

14. FATHER'S NAME — FIRST: James — MIDDLE: Edward — LAST: Morrison

15. MOTHER'S MAIDEN NAME — FIRST: Ada — MIDDLE: Carrie — LAST: Brooks

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

16b. (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 220340024

17. INFORMANT: Dawson M. Weedon — ADDRESS: 4527 Mountville Road Frederick, Md. 21701

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinoma Colon — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 mo year

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from MAY 19 86 to December 19 88, that (I) (we) last saw the deceased alive on Nov 24 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: L Kinland — DEGREE: MD — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 12-5-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): L KINLAND

22e. ADDRESS: 610 NINTH AVE, BRUNSWICK, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 12/08/88

23c. NAME OF CEMETERY OR CREMATORY: Resthaven Mem. Gardens

23d. LOCATION — CITY OR TOWN: Frederick — COUNTY: Frederick — STATE: MD

24. FUNERAL DIRECTOR — NAME: John T. Williams Funeral Home — ADDRESS: 100 Petersville Rd. Brunswick, MD 21701

25a. DATE REC'D. BY REGISTRAR: DEC 12 1988

25b. REGISTRAR'S SIGNATURE: [signature]

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

017966 DEC 88 Film G649 item 1 3-3 89 rja

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

83 REG. NO. 36773

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: ELINOR | Middle: ~~FROST~~ Cline | Last: WEBB | 2a. DATE OF DEATH Month Day Year: December 17, 1988 | 2b. HOUR: 10:10a M | |
| 3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH Month Day Year: Dec. 26, 1895 | 6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS. | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick, MD. | | |
| 10. CITY OR TOWN OF DEATH: Frederick | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Homewood Retirement Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: None | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Frederick | 13c. CITY OR TOWN: Frederick | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 201 West Second Street/21701 | |
| 14. FATHER'S NAME First: Casper | Middle: Ezra | Last: Cline | 15. MOTHER'S MAIDEN NAME First: Minerva | Middle: I. | Last: Frost |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): None | 16b. SOCIAL SECURITY NO.: 214-74-5683 | 17. INFORMANT: Mrs. Dorothy W. Halpin | ADDRESS: 2905 Manns Lane Baltimore, Md. 21234 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Small cell — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Carcinoma to liver, Primary
DUE TO, OR AS A CONSEQUENCE OF (c): not Identified

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from Many Years 19___ to 12/17/88 19___, that (I) (we) last saw the deceased alive on 12/17/88 19___, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: A. Austin Pearre, Jr. | DEGREE: M.D. | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12-19-1988 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): A. Austin Pearre, Jr. M.D. | 22e. ADDRESS: 300 West 9th Street Frederick, Md. 21701 | | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12-21-1988 | 23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Frederick, Frederick, Md. |
| 24. FUNERAL DIRECTOR: R.E. DAILEY & SON, P.A. | ADDRESS: 1201 N. Market Street Frederick, Md. 21701 | 25a. DATE REC'D. BY REGISTRAR: DEC 19 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

BP 12

DHMH - 1650M 1/81 (VRA 15, 4)

17269 DEC 27 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

S 8 3 6 7 7 4
REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH | DAY | YEAR | 2b. HOUR |
|---|---|---|---|---|---|---|
| ELI | D | BEACHY | 12 | 5 | 1988 | 4:43 a M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Male | White | Dec. 9, 1904 | 83 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Pennsylvania | USA | | Garrett MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Oakland | Garrett Co. Memorial Hospital | Farmer | Gen. Farming |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Garrett | Oakland | YES ☐ NO ☒ | Rt. 2 Box 282 21550 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Daniel | S. | Beachy | Amanda | | Miller |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | | N/A | Esther V. Beachy - same as 13 |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia, Bilateral — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I **certify** that (I) (this hospital) attended the deceased from December 2, 1988, to December 5, 1988, that (I) ~~(two)~~ last saw the deceased alive on December 4, 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Robert H. Leighton, MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 5 Dec 1988 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Herbert H. Leighton, MD | Oak @ 5th Sts., Oakland, Maryland 21550 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12/8/88 | Slaubaugh Cemetery | Oakland / Garrett / Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Robert H. Durst | Durst Funeral Home - Oakland, Maryland 21550 | DEC 6 '88 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

017054 DEC 22 '88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3775

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH KNOWN / ESTIMATED | MONTH | DAY | YEAR | 2b. HOUR |
|---|---|---|---|---|---|---|---|
| Luvalla | Ann | CAMERON | XX | 12 | 9 | 19 88 | ? M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. | 2c. DATE PRONOUNCED DEAD | MONTH | DAY | YEAR | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Female | White | Nov. 18, 1949 | 39 YRS. | | | | | | 12 | 11 | 19 88 | 2:00 P M |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| West Virginia | USA | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | Garrett MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Oakland | Route #1, Box 212 | Housewife | Home |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
|---|---|---|---|---|---|
| MD | Garrett | Oakland | YES [ ] NO [X] | Rt. 1, Box 212 | 21550 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Sherman | R. | Pyles | Ida | Elbertha | O'Brien |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | | 233-06-9265 | Joseph R. Pyles, Oakland, MD 21550 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Metastatic Carcinoma - Brain | 6 Months |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Oat Cell Carcinoma of the left lung | 18 months |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES [ ] NO XX |

| 21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [XX] and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE Herbert H. Leighton M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 11 Dec 1988

EXAMINER'S NAME (TYPE OR PRINT) Herbert H. Leighton, M.D. ADDRESS Oak @ 5th Sts., Oakland, MD 21550

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| burial | 12/13/88 | Bayard Cemetery | Oakland, | Garrett, | Maryland |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25. DATE ACCEPTED BY REGISTRAR | 25a. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Bradley A. Stewart | Oakland, Maryland 21550 | DEC 19 '88 | |

BP

DHMH - 17
(VR A15 ME (5))

0197 15 JAN 19 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36776
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Roxie | MIDDLE: Ruth | LAST: DAVIS | 2a. DATE OF DEATH MONTH DAY YEAR: December 26, 1988 | 2b. HOUR: 7:50 A M | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: April 9, 1904 | 6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. Va. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Garrett MD. | | |
| 10. CITY OR TOWN OF DEATH: Oakland | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Dennett Road Manor Nursing Home | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Garrett | Deer Park | YES ☐ NO ☒ | Rt. 3 Box 10 21550 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | |
|---|---|---|
| Robert Y. Davis | Laura Virginia Day | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | IF YES, GIVE WAR OR DATES | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 213-50-4937 | Mrs. Jackie Kenner | 903 Holly Lane - Mt. Lake Park, Md 21550 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): diabetes, hypertension, hyponatremia

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Margaret A Kaiser MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/27/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Margaret A. Kaiser, M.D. | 311 N. 4th St. Oakland, Md. 21550 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12/28/88 | Flanagan Hill Cemetery | Davis / Tucker / W. Va. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Robert M. Durst — Durst Funeral Home - Oakland, Maryland 21550 | DEC 27 '88 | Julia Davidson-Randall |

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

016930 DEC 22 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36777 REG. NO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR | |
| Elva | Ola | Dunson | 12-14-1988 | 10:15 P.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| Female | Caucasian | 6-6-1901 | 87 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| W.Va. | USA | | Garrett MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Oakland | Garrett County Memorial Hospital | | Housewiffe | Domestic | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| W.Va. | Preston | Terra Alta | YES [X] NO [ ] | 208 Railroad Ave. |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Minor | | Hurst | Rosa | | Oldaker |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 232-96-4685 | William C. Dunson | 208 railroad Ave. Terra Alta, WV 26764 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF (b) Atrial Fibrillation

DUE TO, OR AS A CONSEQUENCE OF (c) Ex Chip

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Roger Lewis MD | ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roger Lewis, M.D. | 22e. ADDRESS Terra Alta, WV 26764 | |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12-17-1988 | Terra Alta Cemetery | Terra Alta / Preston / W.Va. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Arthur H. Wright | Terra Alta, WVa | DEC 21 1988 | Julia Davidson-Randolph |

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

016021 DEC 13 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 3677 8
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please see instructions on papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Paul / / Frantz | | | 2a. DATE OF DEATH MONTH DAY YEAR: December 3, 1988 | 2b. HOUR: 5:01 PM |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Aug. 4, 1901 | 6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Garrett County MD. | |
| 10. CITY OR TOWN OF DEATH: Oakland | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Garrett Co. Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Hvy Equip. Oper./ | 12b. KIND OF BUSINESS OR INDUSTRY: Coal |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Garrett | 13c. CITY OR TOWN: Friendsville | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: Second Ave. 2153 |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST: Charles / T. / Frantz | | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Edith / / Friend | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): --- | 16b. SOCIAL SECURITY NO.: 167-03-1897 | 17. INFORMANT: Owen Frantz | ADDRESS: P.O. Box 214 Friendsville, MD21531 |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CVA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO, OR AS A CONSEQUENCE OF (b): Carotid Artery Stenosis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Generalized ASHD

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/1, 19 88, to 12/3, 19 88, that (I) (we) last saw the deceased alive on 12/3, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: TJJ — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED:

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Thomas Johnson — 22e. ADDRESS: 411 North, 4th Street, Oakland, MD

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/6/88 | 23c. NAME OF CEMETERY OR CREMATORY: Blooming Rose Cem. | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Friendsville Garrett, MD. | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: Ronald Newman, Grantsville, Maryland. | | 25a. DATE REC'D BY REGISTRAR: DEC 05 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

017246 DEC 27 88 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 3677 9

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The copies on page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to any removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other abnormal event, the medical examiner must be notified of date

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST: Mildred | MIDDLE: Arbutus | LAST: Hamilton | 2a. DATE OF DEATH MONTH DAY YEAR: Dec. 16, 1988 | 2b. HOUR: 11:00 pm |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Sept. 27, 1905 | 6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Garrett MD. | | |
| 10. CITY OR TOWN OF DEATH: Oakland | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Garrett Co. Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: W. Va. | 13b. COUNTY: Mineral | 13c. CITY OR TOWN: Keyser | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 61 E Street 99999 | |
| 14. FATHER'S NAME FIRST: Edgar | MIDDLE: -- | LAST: Tucker | 15. MOTHER'S MAIDEN NAME FIRST: Ida | MIDDLE: -- | LAST: Unk. |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): None | 16b. SOCIAL SECURITY NO.: 233 96 4763 | 17. INFORMANT ADDRESS: Mrs. Betty Jean Hixenbaugh 61 E. St. Keyser W.Va. 26726 | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 Days

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Senile Dementia

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: — | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: — | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from July 31, 19 87, to DECEMBER 16 19 88, that (I) (we) last saw the deceased alive on December 16 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: W Naumann | DEGREE: MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12-18-88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Walter Naumann MD | 22e. ADDRESS: Accident MD 21520 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/19/88 | 23c. NAME OF CEMETERY OR CREMATORY: Queens Point Cemetery | 23d. LOCATION CITY OR TOWN: Keyser | COUNTY: Mineral STATE: W.Va. |
| 24. FUNERAL DIRECTOR (NAME): Harold W. McKenzie | ADDRESS: Keyser, W.Va. | 25a. DATE REC'D. BY REGISTRAR: DEC 21 1988 | 25b. REGISTRAR'S SIGNATURE: [signature] | |
| | Harold W. McKenzie Funeral Home, 111 S. Mineral St. | | | |

BP

DHMH - 16 50M 1/88 (VRA 15, 4)

017270 DEC 27 88 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 5 8 3 6 7 8 0

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Eileen | MIDDLE: Lavern | LAST: HARSH | 2a. DATE OF DEATH MONTH DAY YEAR: December 12, 1988 | 2b. HOUR: 940 PM | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: July 6, 1921 | 6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Garrett MD. | | |
| 10. CITY OR TOWN OF DEATH: Oakland | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Dennett Road Manor Nursing Home | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Home | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
|---|---|---|---|---|---|
| WV | Preston | Aurora | YES [ ] NO [X] | Rt. 1, Box 161 | 26705 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Chalmer | Edwin | Clegg | Celia | ------- | Varner |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | | 152-14-9362 | Harold A. Harsh, See #13 above |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myelogenous Leukemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 mos Mo
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Malnutrition

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| [ ] | | |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | | |

22a. I certify that (I) (this hospital) attended the deceased from July 19 88 to December 19 88, that (I) (we) last saw the deceased alive on December 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Robert M Coughlin | ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] | 12/13/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Robert M Coughlin | PO Box 8 Elkins, WV 26716 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| burial | 12/15/88 | Kanawha Baptist Cemetery | Parkersburg, Wood, West VA |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Bradley A. Stewart | Oakland, Maryland 21550 | DEC 13 '88 | Julia Davidson-Randall |

BP

DHMH - 1650M 1/81 (VRA 15, 4)

018309 JAN-8-89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

88 REG. NO. 036781

| 1. DECEASED NAME. (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Madeline | Josephine | Harvey | Dec. 13, 1988 | 2:10A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| female | white | 05-16-1922 | 66 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| MD | USA | | Garrett MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Oakland | Garrett Co. Memorial Hospital | housewife | own home |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MD | Garrett | Kitzmiller | YES ☐ NO ☒ | Star Route /21538 |

| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |
|---|---|
| Joseph Moore | Lucy J. Iman |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| no | | 216-38-1709 | Ronald Harvey, Kitzmiller, MD |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Probable Acute Myocardial Infarction | one hr. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Chronic Obstructive Pulmonary Disease; Chronic Renal Failure

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) this hospital) attended the deceased from ____, 19 87, to 12/9, 19 88, that I (we) last saw the deceased alive on 12/9, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|---|
| Karl E. Schwalm | MD | | 12/14/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| KARL E. SCHWALM | OAKLAND, MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12-15-88 | Deer Park Cemetery | Deer Park Garrett MD |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| David A. Burdock, Kitzmiller, MD | DEC 21 1988 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pages 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 6

DHMH - 16 60M 7/84
(VRA 15, 4)

018444 JAN -9 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

83 REG. NO. 36782

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH | DAY | YEAR / 2b. HOUR |
| Ricky | LaVan | Hauser | Dec. | 31 | 1988 / 10:31P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
|---|---|---|---|---|---|
| Male | white | Dec. 4 1953 | 35 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | | Garrett MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Hutton | Rt. 39 | Manager | Store |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Garrett | Oakland | YES ☒ NO ☐ | P.O. Box 12 21550 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Elmer / / Hauser | Kathryn / / Hinkle |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | Vietnam Era | 216-60-0350 | Kathryn Hauser | Oakland, MD |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) acquired immune deficiency syndrome — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. **I certify** that (I) (this hospital) attended the deceased from Dec, 19 87, to Dec, 19 88, that (I) (we) last saw the deceased alive on Dec 28 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Margaret Kaiser MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| KAISER | 311 N 4th Ste 3 Oakland, Md 21550 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| cremation | Jan. 1, 1989 | Smithsburg Crematory | Smithsburg Wash. MD |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Dennis L. Davis Davis Funeral Home | Rt. 3 Box 78 Smithsburg, MD | JAN 30 '89 | Julia Davidson-Randall |

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

019714 JAN 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 5 8 3 6 7 8 3 7

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH KNOWN XX ESTIMATED ☐ MONTH | DAY | YEAR | 2b. HOUR |
| Lola | Reith | KING | 12 | 27 | 19 88 | 7:11 p M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN | 2c. DATE PRONOUNCED DEAD MONTH | DAY | YEAR | 2d. HOUR |
| Female | White | April 24 1909 | 79 YRS. | | | 12 | 27 | 19 88 | 7:11 p M |

| | | | |
|---|---|---|---|
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
| Maryland | USA | | Garrett MD. |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| Oakland | Garrett County Memorial Hospital | Window Clerk | Post Office |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS |
| Maryland | Garrett | Deer Park | | Rt. 4 Box 395 21550 |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | | |
| Emanuel B. King | Laura Mae Friend | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
| No | 215-10-7520 | Mrs. Betty Beckman - Deer Park, Md. 21550 | Rt. 4 Box 223 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Ventricular Arrhythmia | 1 hour |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Ischemic Heart Disease | Several yrs. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Arteriosclerotic Cardio-Vascular Disease | Unknown |

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO XX |
| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Herbert H. Leighton M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 28 Dec 1988

EXAMINER'S NAME (TYPE OR PRINT) Herbert H. Leighton, M.D. ADDRESS Oak @ 5th Sts., Oakland, MD 21550

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
| Burial | 12/30/88 | Garrett Memorial Gardens | Oakland | Garrett | Maryland |

| | | |
|---|---|---|
| 24. FUNERAL DIRECTOR NAME | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| Durst Funeral Home - Oakland, Maryland 21550 | DEC 30 '88 | Julia Kirkson-Randall |

BP

DHMH - 17
(VR A15 ME (5))

016925 DEC 21 '88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO. 3 6 7 8 4

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Robert | Carroll | Moorehead | December 13, 1988 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
|---|---|---|---|---|---|
| Male | White | 8 19 1905 | 83 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | | Garrett County MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Accident | Maust Home Care | Ret. Westvaco | Paper |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Garrett | Bloomington | YES [X] NO [ ] | Box 21523 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Robert | C | Moorehead | Emma | | Green |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | 216 07 2350 | Mrs. Dessie Moorehead | Bloomington Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiorespiratory failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 hours

DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) Cellulitis, UTI, Decubiti,

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Renal Failure (chronic), Peripheral vascular disease

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 10/26, 19 88, to 12/13, 19 88, that (I) (we) last saw the deceased alive on 12/7, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED |
|---|---|---|---|
| Lawrence L. Rentschler | MD | | 12/16/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Lawrence L. Rentschler MD | Friendsville Md 21531 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Burial | 12/16/88 | Garrett Mem. Gardens | Oakland Garrett Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Wayne Bock | Westernport, Md. 21562 | DEC 20 1988 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner, police, or coroner must be notified by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

DHMH-HS 60M 7/84
(VRA 15, 4)

DWG NO. 64-1-1
SCALE: NONE
DRAWN BY: [illegible]

017969 DEC -3 89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO. 036785

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
| Alberta | Pearl | Pritt | 12-19-1988 | 10:50 P.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
|---|---|---|---|---|---|
| Female | Caucasian | 5-11-1926 | 62 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | | Garrett MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Oakland | Garrett County Memorial Hospital | Housewife | Domestic |

**USUAL RESIDENCE** (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| W.Va. | Preston | Terra alta | YES XX NO ☐ | 101 Highland Ave. 99999 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Newton | Wesley | McRobie | Carrie | May | Puffenbarger |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 216-22-6930 | Lawrence pritt | 101 Highland AVe. Terra Alta, WV 26764 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Multiple Embolic CVA's

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Atrial Fib CHF

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I **certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| [signature] | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | |

| 22d. PHYSICIAN'S NAME (TYPED OR PRINT) | 22e. ADDRESS |
|---|---|
| | |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12-22-1988 | Terra Alta Cemetery | Terra Alta / Preston / W.Va. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Arthur H. Wright | Terra Alta, WVa | DEC 29 1988 | Julia Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

0197 16 JAN 1989

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 3678 6

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows pay injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR | |
| Rose | Clara | Raymond | December 23, 1988 | 12:15 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| Female | X White | Sept. 10, 1907 | 81 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑ | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | USA | | Garrett County | | MD. |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Oakland | Dennett Road Manor Nursing Home | | Homemaker | Own Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Maryland | Garrett | Friendsville | YES ☒ NO ☐ | Park Street, Box 11 21531 | |
| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
| Henry | | Shevel | Ida | | Kerling |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS | |
| No | ------ | 215-12-2147 | Mrs. Shirley Thomas | Route 5, Box 190T Oakland, MD 21550 | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): chronic renal failure dementia

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| | | | |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 4/ 19 88 to 12/23/ 19 88, that (I) (we) last saw the deceased alive on 12/22/ 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I)(we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
| Margaret Kaiser | MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12-23-88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KAISER | 22e. ADDRESS 311 N 4th St Ste 3 Oakland | | |

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
| Burial | 12/26/88 | Steele Cemetery | Friendsville, | Garrett, | MD |

24. FUNERAL DIRECTOR NAME: Ruth K. Peterson ADDRESS: Grantsville, MD

DATE RECEIVED BY REGISTRAR: DEC 27 88

25. REGISTRAR'S SIGNATURE: Gina Davidson-Kendall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

019717 JAN 1989

1- FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

88 36787 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Juris | Middle: Vitauts | Last: Reneslacis | 2a. DATE OF DEATH Month: 12 Day: 25 Year: 1988 | 2b. HOUR: 12:30A |
| 3. SEX: M | 4. RACE: White | 5. DATE OF BIRTH Month: 6 Day: 13 Year: 1938 | 6. AGE (IN YEARS LAST BIRTHDAY): 50 YRS. | IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Latvia | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Garrett MD. | |
| 10. CITY OR TOWN OF DEATH: Kitzmiller | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Home | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Minister | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md. | 13b. COUNTY: Garrett | 13c. CITY OR TOWN: Kitzmiller | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET ADDRESS: Box 200 21538 |
| 14. FATHER'S NAME First: Juris | Middle: | Last: Reneslacis | 15. MOTHER'S MAIDEN NAME First: Vera | Middle: | Last: Bebris |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 045-28-5169 | 17. INFORMANT: Earlean Reneslacis | ADDRESS: Kitzmiller, Md. | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma Colon c metastases — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 1986, 19__, to 1988, 19__, that (I) (we) last saw the deceased alive on Nov 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: [signature] | DEGREE: D.O. ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Miller P. Daniel | 22e. ADDRESS: 311 N 4th St Oakland, MD | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/28/88 | 23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Mem. Park | 23d. LOCATION CITY OR TOWN: Allentown COUNTY: Lehigh STATE: Pa. |
| 24. FUNERAL DIRECTOR NAME: D.A. Burdock | ADDRESS: Kitzmiller, Md. | 25a. DATE REC'D. BY REGISTRAR: DEC 27 '88 | 25b. REGISTRAR'S SIGNATURE: [signature] |

BP

DHMH 16 50M 1/81 (VRA 15, 4)

017271 DEC 27 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36788

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 31. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST: Freeman | MIDDLE: ~~Wilbur~~ ~~Walker~~ | LAST: Sines | 2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ | MONTH: 12- | DAY: 8- | YEAR: 19 88 | 2b. HOUR: M |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: MONTH May DAY 13, YEAR 1914 | 6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS. | IF UNDER 1 YR.: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD: MONTH 12- DAY 8- YEAR 19 88 | | 2d. HOUR: 5:20P M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | | 9. BALTIMORE CITY OR COUNTY OF DEATH: Garrett County MD | | | | |
| 10. CITY OR TOWN OF DEATH: Oakland | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Garrett County Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Miner-Timberman | 12b. KIND OF BUSINESS OR INDUSTRY: Coal & Lumber | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Garrett | 13c. CITY OR TOWN: Friendsville | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: Rt. 1, Box 210, 21531 | | | | |
| 14. FATHER'S NAME: FIRST Charles MIDDLE Henry LAST Sines | 15. MOTHER'S MAIDEN NAME: FIRST Amanda MIDDLE ~~Van~~ LAST VanSickle | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | 16b. SOCIAL SECURITY NO.: 198-18-6942 | 17. INFORMANT: Janet L. Sines | ADDRESS: Rt. 1, Box 210, Friendsville, MD 21531 | | | | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☒ NO ☐ |
| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: [signature] TITLE (SPECIFY): Chief M.D. MEDICAL EXAMINER DATE SIGNED: 12-9-88

EXAMINER'S NAME (TYPE OR PRINT): John E. Smialek, M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Dec. 11, 88 | 23c. NAME OF CEMETERY OR CREMATORY: Sand Spring Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Friendsville, Garrett, MD |
| 24. FUNERAL DIRECTOR NAME: A. Lynn Furrow | ADDRESS: Grantsville, MD | 25a. DATE REC'D BY REGISTRAR: DEC 12 88 | 25b. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall |

07 25M BP

DHMH - 17
(VR A15 ME (5))

17272 DEC 27 88

FOR 1- STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 7678 9

1. DECEASED NAME (TYPE OR PRINT): First: Kenwood; Middle: Floyd; Last: STARK

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month: 12 Day: 1 Year: 19 88

2b. HOUR: 5:15 a M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: Month: Dec. Day: 13, Year: 1918

6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS. IF UNDER 1 YR. MONTHS: DAYS: IF UNDER 24 HRS. HOURS: MIN.:

2c. DATE PRONOUNCED DEAD: Month: 12 Day: 1 Year: 19 88

2d. HOUR: 5:15 am

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Garrett MD

10. CITY OR TOWN OF DEATH: Oakland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Garrett County Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Engineer

12b. KIND OF BUSINESS OR INDUSTRY: Electrical

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Garrett

13c. CITY OR TOWN: Oakland

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS: Rt. 1 Box 350L 21550

14. FATHER'S NAME: First: William; Middle: Floyd; Last: Stark

15. MOTHER'S MAIDEN NAME: First: Florence; Middle: Irene; Last: (unknown)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes (WW II)

16b. SOCIAL SECURITY NO.: 230-09-2301

17. INFORMANT ADDRESS: Mrs. Anastasia M. Stark - same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Ventricular Arrhythmia — Approximate interval between onset and death: Minutes

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Ischemic Heart Disease — Several Mos.

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic Cardio-Vascular Disease — Unknown

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Herbert H. Leighton M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 1 Dec 1988

EXAMINER'S NAME (TYPE OR PRINT): Herbert H. LEighton, M.D. ADDRESS: Oak @ 5th Sts., Oakland, MD 21550

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 12/3/88

23c. NAME OF CEMETERY OR CREMATORY: Garrett Memorial Garden

23d. LOCATION CITY OR TOWN: Oakland COUNTY: Garrett STATE: Md.

24. FUNERAL DIRECTOR NAME AND ADDRESS: Robert M. Durst Durst Funeral Home - Oakland, Maryland 21550

25a. DATE REC'D BY REGISTRAR: DEC 2 '88

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rondell

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/87 25M BP

DHMH - 17 (VR A15 ME (5))

019721 JAN 19

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

S 8 3 6 7 9 0
REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | Mary | Elizabeth | SUKOW | 2a. DATE OF DEATH MONTH DAY YEAR | December 16, 1988 |
| 2b. HOUR | 6:00 A M | | | | |
| 3. SEX | Female | | | | |
| 4. RACE | White | | | | |
| 5. DATE OF BIRTH MONTH DAY YEAR | Oct. 15, 1923 | | | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 65 YRS | | | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Maryland | | | | |
| 7b. CITIZEN OF WHAT COUNTRY? | USA | | | | |
| 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | | | | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Garrett MD. | | | | |
| 10. CITY OR TOWN OF DEATH | Oakland | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Garrett Co. Memorial Hospital | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Florist | | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | Flower | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Maryland | | | | |
| 13b. COUNTY | Garrett | | | | |
| 13c. CITY OR TOWN | Oakland | | | | |
| 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | | | | | |
| 13e. STREET ADDRESS | Weber Road 21550 | | | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | Ralph E. Weber | | | | |
| 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Mary Bond | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | No | | | | |
| 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | 235-30-3931 | | | | |
| 17. INFORMANT ADDRESS | Edward Weber - 1945 Versailles St. Sarasota, Florida34239 | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF
(b) end-stage Chronic obstructive pulmonary disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/13, 19 88, to 12/16, 19 88, that (I) (we) last saw the deceased alive on 12/15, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE / DEGREE | Donald R Richter MD — ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED 12/16/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | D Richter MD | 22e. ADDRESS Oakland, Maryland 21550 |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE | |
| Burial | 12/19/88 | Weber Cemetery | Oakland | Garrett Md. |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | Robert M. Durst — Durst Funeral Home - Oakland, Maryland 21550 | 25a. DATE REC'D BY REGISTRAR | DEC 20 '88 | 25b. REGISTRAR'S SIGNATURE — Julia Davidson Randall |

R BP

DHMH - 16 50M 1/81 (VRA 15, 4)

017055 DEC-22-88 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36791

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST: Della | MIDDLE: Mae | LAST: WARZINSKI | 2a. DATE OF DEATH: KNOWN XX / ESTIMATED ☐ | MONTH: 12 | DAY: 14 | YEAR: 19 88 | 2b. HOUR: 11:04 a M |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: MONTH Dec. DAY 28, YEAR 1920 | 6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS. | IF UNDER 1 YR. MONTHS: | DAYS: | IF UNDER 24 HRS. HOURS: | MIN: | 2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 14 YEAR 19 88 | 2d. HOUR: 11:04 a M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | | 9. BALTIMORE CITY OR COUNTY OF DEATH: Garrett MD. | | | | | |
| 10. CITY OR TOWN OF DEATH: Oakland | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Garrett County Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Home | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD | 13b. COUNTY: Garrett | 13c. CITY OR TOWN: Kitzmiller | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: Star Route 21538 | | | | | |
| 14. FATHER'S NAME FIRST: George | MIDDLE: A. | LAST: Sanner | 15. MOTHER'S MAIDEN NAME FIRST: Effie | MIDDLE: ----- | LAST: Stillwagon | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 175-14-4032 | 17. INFORMANT ADDRESS: Velma DeWitt, See #13 above | | | | | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Renal Failure - End Stage Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Months

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Diabetes Mellitus — Years

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Peripheral Vascular Disease - Both legs amputated in the past

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO XX |
| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry XX, and in my opinion death resulted from: Natural couses XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Herbert H Leighton M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 14 Dec 1988

EXAMINER'S NAME (TYPE OR PRINT): Herbert H. Leighton, M.D. ADDRESS: Oak @ 5th Sts., Oakland, Maryland 21550

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): burial | 23b. DATE: 12/17/88 | 23c. NAME OF CEMETERY OR CREMATORY: Mt. Tabor Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Springfield, Fayette, PA |
| 24. FUNERAL DIRECTOR NAME: Bradley A. Stewart | ADDRESS: Oakland, Maryland 21550 | 25a. DATE REC'D BY REGISTRAR: DEC 14 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rondell |

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 036792

1 - FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: ANNA | MIDDLE: V | LAST: Acker | 2a. DATE OF DEATH MONTH DAY YEAR: Dec 26 88 | 2b. HOUR: 1:42 AM | |
| 3. SEX: F | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Oct. 26 1918 | 6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD. | | |
| 10. CITY OR TOWN OF DEATH: Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hosp. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Own home | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Harfofd | 13c. CITY OR TOWN: Darlington | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 1553 Deerfield Road 21034 | |
| 14. FATHER'S NAME FIRST: Benjamin | MIDDLE: Franklin | LAST: Temple | 15. MOTHER'S MAIDEN NAME FIRST: Katie | MIDDLE: Swift | LAST: Lee |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): ---------- | 16b. SOCIAL SECURITY NO.: 218-38-3784 | 17. INFORMANT: James B. Acker | ADDRESS: Bel Air, MD 2027 Waverly Drive | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF (b): MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF (c): ARTERIOSCLEROSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1R PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/22, 19 88, to 12/26, 19 88, that (I) (we) last saw the deceased alive on 12/25, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Dante M. Monakil M.D. DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/26/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): DANTE M. MONAKIL
22e. ADDRESS: Havre de Grace, Md 21078

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/29/88 | 23c. NAME OF CEMETERY OR CREMATORY: Dublin Southern | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Darlington Harford MD | |
| 24. FUNERAL DIRECTOR NAME: Harkins | ADDRESS: Funeral Home 600 Main St. Delta, PA | 25a. DATE REC'D. BY REGISTRAR: DEC 28 1988 | 25b. REGISTRAR'S SIGNATURE | |

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

0188801 JAN 11 89

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH 88 36793

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: Martha | Middle: Jane | Last: Anderson | 2a. DATE OF DEATH: Month 12 Day 29 Year 88 | 2b. HOUR: 3 P M |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: Oct. 11, 1910 | 6. AGE (In years last birthday): 78 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
| 7a. BIRTHPLACE (State or foreign country): North Carolina | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Harford County Md. | | |
| 10. CITY OR TOWN OF DEATH: Edgewood | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 1817 Truxton Court | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: -- | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Harford | 13c. CITY OR TOWN: Edgewood | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER: 1817 Truxton Court 21040 | |
| 14. FATHER'S NAME First: Mack | Middle: -- | Last: Irwin | 15. MOTHER'S MAIDEN NAME First: Mary | Middle: Elizabeth | Last: Poe |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no | (If yes give war or dates of service): none | 16b. SOCIAL SECURITY NO.: 213-60-6466 | 17. INFORMANT: Leon Anderson, 1817 Truxton Court. | Address: Md. 21040 Edgewood | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Pneumonitis | 24 hrs |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Parkinson's Disease- advanced | 12 yrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County | |

22a. **I certify** that (I) (this hospital) attended the deceased from 4/29/73, 19___, to 12/29, 1988 saw the deceased alive on 12/28 1988, and that to (my) (our) opinion death occurred on the date causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Phyllis K. Pullen MD | DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. | |
| 22d. PHYSICIAN'S NAME (Type): Phyllis K. Pullen MD | 22e. ADDRESS: 2807 Jerusalem Rd, K | | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Dec. 31, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: Meadowridge Mem. Park Cem | 23d. LOCATION (City: Elkrido |
| 24. FUNERAL DIRECTOR: Howard K. McComas III, Abingdon, Md. 21009 | ADDRESS | 25a. REC'D BY REGISTRAR DATE: DEC 30 88 | |

DHMH - 163/72 25M (VR A15 (4))

018343 JAN -8

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 53 3 5 7 9 4

1. DECEASED NAME (TYPE OR PRINT): FIRST Grace MIDDLE Fox LAST Arbaugh
2a. DATE OF DEATH: MONTH 12 DAY 29 YEAR 88
2b. HOUR 1130 A.M.
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: MONTH 9 DAY 9 YEAR 1902
6. AGE (IN YEARS LAST BIRTHDAY): 86 IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD.
10. CITY OR TOWN OF DEATH: Bel Air
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): BelAir COnvalsent Center BelAir,Md
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Procurement CLerk
12b. KIND OF BUSINESS OR INDUSTRY: U.S.Govt.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md.
13b. COUNTY: BAltimore
13c. CITY OR TOWN: Carney
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: 3146 E.Joppa Rd. BAlto.,Md21234

14. FATHER'S NAME: FIRST Harry MIDDLE LAST Fox
15. MOTHER'S MAIDEN NAME: FIRST Grace MIDDLE LAST Yingling
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 212-18-7951
17. INFORMANT ADDRESS: Virginia A.Richards 4141loch Lomond Dr. Balto., Md. 21236

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1/2 hour
DUE TO, OR AS A CONSEQUENCE OF (b): SCVD — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): dementia

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 7/22 19 88 to 12/29 19 88, that (I) (we) last saw the deceased alive on 12/6 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: P Dubyoski DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/29/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Patricia Dubyoski
22e. ADDRESS: 1131 Bel Air Rd Bel Air MD 21014

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation
23b. DATE: 12-30-88
23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cremetory
23d. LOCATION CITY OR TOWN: BAltimore, Md. COUNTY STATE

24. FUNERAL DIRECTOR NAME AND ADDRESS: Walter Brooks Bradley, Inc Dundalk, Md. 21222
25a. DATE REC'D. BY REGISTRAR: DEC 30 1988
25b. REGISTRAR'S SIGNATURE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 3679 5

1158893 DEC 12 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use by the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH | DAY | YEAR | 2b. HOUR |
| MICHAEL | I | ANNETTA | 12 | 5 | 88 | 1103P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH | DAY | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | # UNDER 1 YEAR MONTHS | DAYS | # UNDER 24 HRS HOURS | MIN. |
|---|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | 10 | 2 | 08 | 80 YRS. | | | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARITAL STATUS | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| PA | USA | MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | HARFORD CO. MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| BEL AIR | 200 CROCKER DR. APT. C | BUSINESS MANAGER | SCHOOL FOR THE BLIND |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | HARFORD | BEL AIR | YES ☐ NO ☐ | 200 C Crocker Dr - Bel Air 21014 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| NICHOLAS | | ANNETTA | MARY | | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| YES | NAVY | 1942-45 | 169-18-5149 WIFE | SAME AS deceased - |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | LIVER FAILURE - OBSTRUCTIVE JAUNDICE | 1 M |
| DUE TO, OR AS A CONSEQUENCE OF (b) | METASTATIC CA OF THE STOMACH | 1 year |
| DUE TO, OR AS A CONSEQUENCE OF (c) | unresectable ca of the stomach | 2 1/2 years |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 7-3-85 | CA OF THE STOMACH | YES ☐ NO ☑ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) ~~this hospital~~ attended the deceased from 6-25-85, 19____, to 12-1-, 19 88, that (I) ~~we~~ last saw the deceased alive on 12-1-88, 19____, and that in (my) ~~our~~ opinion death occurred on the date and hour and from the causes stated above. (I)(we) ~~have~~ did not view the body after death.

| 22b. SIGNATURE | DEGREE | | | | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Roberto Ferrer | MD | ATTENDING PHYSICIAN ☐ | MEDICAL DIRECTOR ☑ | STAFF PHYSICIAN ☐ | 12-6-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| ROBERTO O. FERRER | 7600 OSLER DR TOWSON - MD 21204 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Removal | 12-6-88 | | | | |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| State Anatomy Board | Baltimore, Md. | DEC 9 1988 | Julia Davidson Randolph |

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

018878 JAN 1 1989

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 36796

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: POLLIA | Middle: M. | Last: ASHFORD | 2a. DATE OF DEATH Month: 12 Day: 22 Year: 88 | 2b. HOUR 9:50 A.M. | |
| 3. SEX: F | 4. RACE: W | 5. DATE OF BIRTH Month: 4 Day: 28 Year: 23 | 6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Kentucky | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD. | | |
| 10. CITY OR TOWN OF DEATH: HAVRE DE GRACE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HARFORD MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret. Machine Oper. | 12b. KIND OF BUSINESS OR INDUSTRY: Bata Shoe | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Harford | 13c. CITY OR TOWN: Aberdeen | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 717 Schofield Rd. 21001 | |
| 14. FATHER'S NAME First: Jeff | Middle: | Last: Mills | 15. MOTHER'S MAIDEN NAME First: Ida | Middle: | Last: Bingham |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | 16b. IF YES, GIVE WAR OR DATES: N/A | 16b. SOCIAL SECURITY NO.: 404-28-3989 | 17. INFORMANT: Sharon Quesada | ADDRESS: 813 Summit Ave. Union City, N.J. 07087 | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b): Congestive heart failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 11/15/88 to 12/22/88, that (I) (we) last saw the deceased alive on 12/22/1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: John D Yun | DEGREE: MD | ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOHN D YUN | 22e. ADDRESS: Hame de grae, MD | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal/Cremation | 23b. DATE: 12/27/88 | 23c. NAME OF CEMETERY OR CREMATORY: R. A. Ferris & Co. | 23d. LOCATION CITY OR TOWN: West Chester, COUNTY: Chester, STATE: Pa. | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399 | 25a. DATE REC'D. BY REGISTRAR: DEC 28 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

017813 DEC 30 88 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36797 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH | DAY | YEAR | 2b. HOUR |
| SAMUEL | --- | BANKS | 12 | 16 | 88 | 3:18 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH | DAY | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|---|---|
| Male | Black | August | 11 | 1911 | 77 YRS. | | | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | | HARFORD MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| HAVRE DE GRACE | HARFORD MEMORIAL HOSPITAL | Dairyman | Mt. Ararat Farms |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Cecil | Port Deposit | YES ☐ NO XX | 2204 Frenchtown Rd. 21904 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Charles | E. | Banks | Sarah | --- | Heard |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | ---- | 218-05-7203 | Frances B. Banks | Port Deposit, Md. 21904 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Ventricular Fibrillation | Minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Widespread Metastatic Adenocarcinoma Lung and Liver | 7 months |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Adeno Carcinoma of Sigmoid Colon | 2 years |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO X | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from ____ 19____ to ____ 19____, that (I) (we) last saw the deceased alive on 12/16/88 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN ☐ / MEDICAL DIRECTOR ☑ / STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|---|
| William G. Esmond | MD | | 12/16/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| WILLIAM G. ESMOND | 131 S UNION AVE, HAVRE DE GRACE, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | Dec. 20, 1988 | Cokesbury Cemetery | Port Deposit | Cecil | Maryland |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Lee A. Patterson & Son | Lee A. Patterson & Son, Perryville, Maryland | DEC 19 '88 | Julia Davidson Randall |

BP 12

DHMH 16 50M 1/81 (VRA 15, 4)

017764 DEC 30 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 036793

1. DECEASED NAME (TYPE OR PRINT): First Ules Middle B. Last Bare (Ules Bornie Bare)
2a. DATE OF DEATH: Month 12 Day 11 Year 88
2b. HOUR: 6 Am
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: Month Oct. Day 6, Year 1930
6. AGE (IN YEARS LAST BIRTHDAY): 58 YRS. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.
10. CITY OR TOWN OF DEATH: Havre de Grace
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Auto Mechanic
12b. KIND OF BUSINESS OR INDUSTRY: Gas Station

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Harford
13c. CITY OR TOWN: Bel Air
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS: 2001 Wheel Road 21014

14. FATHER'S NAME: First Willie Middle O. Last Bare
15. MOTHER'S MAIDEN NAME: First Cordelia Middle Mildred Last Testman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no
(IF YES, GIVE WAR OR DATES): none
16b. SOCIAL SECURITY NO.: 213-30-6923
17. INFORMANT: Thelma M. Bare, ADDRESS 2001 Wheel Road, 21014 Bel Air, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Large Cell CA. Lung with Brain Mets — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Aug, 19 88, to 12-11, 19 88, that (I) (we) last saw the deceased alive on 12-10, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: B Parekh
DEGREE: MD. ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 12-12-88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): B PAREKH MD.
22e. ADDRESS: 1908 HARFORD RD, FALLSTON MD. 21047

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Dec. 14, 1988
23c. NAME OF CEMETERY OR CREMATORY: New Bridge Baptist Cem.
23d. LOCATION: CITY OR TOWN Rising Sun / COUNTY Cecil / STATE Md.
24. FUNERAL DIRECTOR (NAME): Howard K. McComas III, ADDRESS Abingdon, Md. 21009
25a. DATE REC'D BY REGISTRAR: DEC 13 88
25b. REGISTRAR'S SIGNATURE: Lisa Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

017001 DEC 22 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 036799

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | GRACE / BELL / BARNETTE | 2a. DATE OF DEATH MONTH / DAY / YEAR | 12 / 10 / 88 | 2b. HOUR | 11:22 A.M. |
| 3. SEX | F | 4. RACE | W | 5. DATE OF BIRTH MONTH / DAY / YEAR | 3 / 1 / 27 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 61 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS. HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Virginia | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | HARFORD MD. | | | | |
| 10. CITY OR TOWN OF DEATH | HAVRE DE GRACE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | HARFORD MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Ret. Bata Shoe Co. |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Harford | Aberdeen | YES ☒ NO ☐ | 170 Allendale Ave. 21001 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Jesse / Clarence / Ashford | Mary / Ethel / Mergith |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | N/A | 224-36-6875 | Kenneth Wayne Barnette, Same as above |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiorespiratory Arrest | unknown |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Chronic Obstructive Pulmonary Disease | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Arteriosclerotic Heart Disease | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY Ooccurred (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | 21e. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| | | None | |

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

22a. I certify that (I) (this hospital) attended the deceased from 1983, 19__, to 12/10, 19 88, that (I) (we) last saw the deceased alive on 12/10, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Manuel M. [illegible] | MD | ATTENDING PHYSICIAN ☐ | MEDICAL DIRECTOR ☐ | STAFF PHYSICIAN ☐ | 12/10/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| LAZOTTE, MANUEL | 8 Law St Aberdeen, MD 21001 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12/14/88 | Baker Cemetery | Aberdeen / Harford / Md. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399 | DEC 12 '88 | Julia Davidson-Randall |

DHMH - 16 50M 1/81 (VRA 15, 4)

Item#15 Film G648 2/6/89cy

018982 JAN 13 89

1 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

33 36800
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Ruth | Middle: C | Last: Bartlett | 2a. DATE OF DEATH Month Day Year: Dec. 24 1988 |
| 2b. HOUR: 6:35 P M | | | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH Month Day Year: Oct. 10 1907 | 6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD. |
| 10. CITY OR TOWN OF DEATH: Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hosp | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): School Teacher | 12b. KIND OF BUSINESS OR INDUSTRY: Cecil Co. Public Schools |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | |
| 13a. STATE: Maryland | 13b. COUNTY: Cecil | 13c. CITY OR TOWN: Port Deposit | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ |
| 13e. STREET ADDRESS: 345 Blythedale Road 21904 | | | |
| 14. FATHER'S NAME First: William | Middle: James | Last: Bartlett | 15. MOTHER'S MAIDEN NAME First: ~~Mimmie~~ Minnie | Middle: Fay | Last: Cole |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no | (IF YES, GIVE WAR OR DATES): ---- | 16b. SOCIAL SECURITY NO.: 221-10-0269 | 17. INFORMANT: William L. Bartlett | ADDRESS: Rose Valley, PA |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIO PULMONARY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MINUTES
DUE TO, OR AS A CONSEQUENCE OF (b): RECURRENT, INTRACTABLE VENTRICULAR ARRHYTHMIAS — ~4 HRS.
DUE TO, OR AS A CONSEQUENCE OF (c): CONGESTIVE CARDIOMYOPATHY — months.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 1 year prior 19__ to 12/24 19 88, that (I) (we) last saw the deceased alive on 12/24 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12-25-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): BARRY WOHL M.D.

22e. ADDRESS: 2003 Rock Spring Rd. Forest Hill, Md 21050

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremated | 23b. DATE: Dec. 26, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: R.A. Ferris & Co. | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: West Chester / Chester / Penn. |

24. FUNERAL DIRECTOR (NAME AND ADDRESS): Lee A. Patterson & Son, Perryville, Maryland

25. DATE REC'D. BY REGISTRAR: DEC 29 '88

25a. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 15

DHMH - 16 50M 1/81 (VRA 15, 4)

018331 JAN 6 89

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36801

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: LYDIA | MIDDLE: Mabel C. | LAST: COBOURN Beachley | 2a. DATE KNOWN OF DEATH XX / ESTIMATED ☐ MONTH: 12 | DAY: 20 | YEAR: 88 | 2b. HOUR: M |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR: SEPT. 7, 1905 | 6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS. | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 12-20-88 | 2d. HOUR: 10:58 A M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD | | | | |
| 10. CITY OR TOWN OF DEATH: Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): (RET) MUSIC TEACHER | 12b. KIND OF BUSINESS OR INDUSTRY: SELF EMPLOYED | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD | 13b. COUNTY: HARFORD | 13c. CITY OR TOWN: HAVRE de GRACE | 13d. INSIDE CITY LIMITS? YES X NO ☐ | 13e. STREET ADDRESS: 502 CONGRESS AVENUE, APR 206 21078 | | | |
| 14. FATHER'S NAME FIRST: HIRAM | MIDDLE: ELISHA | LAST: COBOURN | 15. MOTHER'S MAIDEN NAME FIRST: DAISY | MIDDLE: | LAST: HAUGHAY | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 212 40 6876 | 17. INFORMANT ADDRESS: CAROL McINTYRE, 613 S. WASHINGTON ST., HdG 21078 | | | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

888 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

IMMEDIATE CAUSE (a) Pulmonary thromboembolism

DUE TO, OR AS A CONSEQUENCE OF (b) Deep leg vein thrombosis of left leg

DUE TO, OR AS A CONSEQUENCE OF (c) Fracture of left femur

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO X |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: 12-13-88 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): Subject fell |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ XX | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): home | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE: 502 Congress Avenue, Harford County, MD |

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Margarita Korell MD TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED: 12-21-88

VC EXAMINER'S NAME (TYPE OR PRINT): Margarita A. Korell, M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 23DECEMBER88 | GROVE PRESBYTERIAN CEMETERY | ABERDEEN, HARFORD CO., MARYLAND |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| MITCHELL-SMITH FUNERAL HOME PA, HAVRE de GRACE, MD 21078 | DEC 23 '88 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18; GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ATONCE WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

07/84 25M

BP 10

DHMH - 17 (VR A15 ME (5))

016448 DEC 15 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 3 6 8 0 2

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: LOUIS | MIDDLE: W. | LAST: BELLMAN, SR. | 2a. DATE OF DEATH MONTH DAY YEAR: 12 10 88 | 2b. HOUR: M |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: 7 20 15 | 6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS. | IF UNDER 1 YEAR MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED XX / NEVER MARRIED / WIDOWED / DIVORCED | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD. | |
| 10. CITY OR TOWN OF DEATH: Joppa | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1108 Old Mountain Rd. North | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Saw Operator-Martin Marietta | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Harford | 13c. CITY OR TOWN: | 13d. INSIDE CITY LIMITS? YES / NO X | 13e. STREET ADDRESS / ZIP CODE: 21085 Joppa, Md. 1108 Old Mountain Rd. North |
| 14. FATHER'S NAME FIRST: Joseph | MIDDLE | LAST: Bellman | 15. MOTHER'S MAIDEN NAME FIRST: Anastasia | MIDDLE | LAST: Chaney |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 218-01-3188 | 17. INFORMANT: Katherine A. Bellman | ADDRESS: 1108 Old Mountain Rd.N. Joppa, Maryland 21085 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolism — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF:
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Rt Pleo femoral thrombosis
DUE TO, OR AS A CONSEQUENCE OF:
(c): AS OF.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO X | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES / NO |
| 21a. ACCIDENT WAS UNDERLYING / OR CONTRIBUTING / CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/8, 19 88, to Date, 19 ____, that (I) (we) last saw the deceased alive on 12/8/88 19 ____, and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: Mamdouh O Darwish — DEGREE: ATTENDING PHYSICIAN X / MEDICAL DIRECTOR / STAFF PHYSICIAN — 22c. DATE SIGNED: 12/12/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Mamdouh Darwish, M.D. (687-7042)

22e. ADDRESS: 9105 Franklin Square Dr. Balto.,Md. 21237

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12-14-88 | 23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Harford Maryland | |
| 24. FUNERAL DIRECTOR NAME: E.F. Lassahn Funeral Home | ADDRESS: 11750 Belair Rd. Bel Air (Kingsville) MD 21015 | 25a. DATE REC'D. BY REGISTRAR: DEC 14 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

BP____

DHMH - 16 60M 7/84
(VRA 15, 4)

0 1 8 1 6 8 JAN -5 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36803 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. DECEASED NAME (TYPE OR PRINT) | FIRST | MIDDLE | LAST |
|---|---|---|---|
| | Mary | Elizabeth | Berthel |

| 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
|---|---|---|---|---|
| | December | 29, | 1988 | 1:00 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH (MONTH DAY YEAR) | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| Female | Caucasian | Sept. 15, 1911 | 77 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Pennsylvania | U.S.A. | MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | Harford MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Street | 4030 Old Rocks Road | Secretary | Commerce |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 21154

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Harford | Street | YES ☐ NO ☒ | 4030 Old Rocks Road |

| 14. FATHER'S NAME | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|---|---|
| | Frank | Hassan | Berthel | | Nina | Blanche | Hallock |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 082-07-2924 | John H. Berthel | Baltimore, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF (b) LUNG CANCER

DUE TO, OR AS A CONSEQUENCE OF (c) (L) HEMISPHERIC CEREBROVASCULAR ACCIDENT

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY (HOUR A.M. P.M. MONTH DAY YEAR 19) | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION (STREET / CITY OR TOWN / COUNTY / STATE) |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Robert W. Wiegefeld MD | ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12-30-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| RW WIEGEFELD MD | 3313 Papermill Rd Phoenix Md 21131 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (CITY OR TOWN / COUNTY / STATE) |
|---|---|---|---|
| Cremation | 12/31/88 | Carroll Crematory | Hampstead, Carroll, Md. |

| 24. FUNERAL DIRECTOR (NAME) | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| M. Gladden Kurtz | Jarrettsville, Md. | JAN 3 1989 | Julia Davidson-Hopkins |

DHMH - 16 60M 7/84
(VRA 15, 4)

C016935 DEC 22 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3630 4

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH | DAY | YEAR | 2b. HOUR |
|---|---|---|---|---|---|---|
| James | | Bishop | 12 | 16 | 1988 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH | DAY | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. | 2c. DATE PRONOUNCED DEAD MONTH | DAY | YEAR | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MALE | BLACK | 09 | 23 | 58 | 30 YRS. | | | | | 12 | 16 | 1988 | 11:15 P M |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | | Harford County MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Havre de Grace | 845 Eric Street | CONSTRUCTION | |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MARYLAND | HARFORD | HAVRE DE GRACE | YES ☒ NO ☐ | 845 ERIE STREET 21078 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| JAMES | ISSAC | BISHOP | THELMA | | FOGLE |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 219-58-5202 | LORAY HALL BISHOP | 1541 JARRETTSVILLE RD. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Smoke and soot inhalation | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 8902 — DUE TO, OR AS A CONSEQUENCE OF (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR XX P.M. MONTH | DAY | YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|---|---|
| | 12 | 16 | 1988 | House fire |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | home | 845 Eric Street | Havre de Grace | Harford | MD |

22a. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: ( ) Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Mario F. Golle Jr MD — TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER — DATE SIGNED 12/17/88

EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. — ADDRESS 111 Penn St. Balto. MD.

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| CREMATION | 12-20-88 | WESTVIEW CREMATORY | BALTIMORE, | MARYLAND | |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| BULLOCK'S MORTUARY | 556 LEWIS STREET | DEC 20 1988 | Julia Davidson-Kendall |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 99. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

16815 DEC 20 88

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36805 REG. NO

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Alfred | MIDDLE: A | LAST: Boyer | 2a. DATE OF DEATH MONTH DAY YEAR: Nov 26 88 | 2b. HOUR: 2 A M | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: May 26 1915 | 6. AGE (IN YEARS LAST BIRTHDAY): 73 yrs. YRS | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD. | | |
| 10. CITY OR TOWN OF DEATH: Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hosp | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Engineering Service | 12b. KIND OF BUSINESS OR INDUSTRY: V.A.M.C., Perry Point Division Md. | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Harford | Havre de Grace | YES [X] NO [ ] | 412 North Union Ave. 21078 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Harry / --- / Boyer | Mary / --- / Clark |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| YES | W.W. II | 218-03-7035 | Mildred A. Boyer | Havre de Grace, Md. |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b): Severe Coronary artery disease

DUE TO, OR AS A CONSEQUENCE OF (c): Cerebrovascular

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: HTN

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 11/17 19 88 to 11/26 19 88 that (I) (we) last saw the deceased alive on 11/26 19 88 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Dante U. Monakil MD | ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 11/26/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DANTE U. MONAKIL | Havre de Grace, Md 21078 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | Nov. 28, 1988 | R.A. Ferris & Company | West Chester / Chester / Pennsylvania |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Lee A. Patterson & Son, Perryville, Maryland | DEC - 5 '88 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

SOM 1/81 4)

018288 JAN 6 '89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36806 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Phyllis | Middle: NMN | Last: Breuning | 2a. DATE OF DEATH Month: 12 Day: 25 Year: 88 | 2b. HOUR 7:30 P M | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH Month: 07 Day: 12 Year: 16 | 6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County, MD. | | |
| 10. CITY OR TOWN OF DEATH: Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Waitress | 12b. KIND OF BUSINESS OR INDUSTRY: Restaurant | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD | 13b. COUNTY: Harford | 13c. CITY OR TOWN: Bel Air | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 106 S. Kelly Ave, Apt. 2, 21014 | |
| 14. FATHER'S NAME First: Antonio | Middle: -- | Last: Barasso | 15. MOTHER'S MAIDEN NAME First: Maria | Middle: --- | Last: Miguagna |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): none | 16b. SOCIAL SECURITY NO.: 212-12-1291 | 17. INFORMANT: Ronald P. Gravitte | ADDRESS: 308 Amy Drive, Abingdon, Md 21009 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b): END STAGE COPD
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART IIa

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 11/21, 19 88, to 12/25, 19 88, that (I) (we) last saw the deceased alive on 12/23, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Roy H. Phillips, M.D. DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 12/26/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ROY H. PHILLIPS 22e. ADDRESS: 2005 ROCK SPRING RD FOREST HILL MD

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Dec. 28, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: Lakeview Mem. Pk. Cem. | 23d. LOCATION CITY OR TOWN: Sykesville | COUNTY: Carroll | STATE: Md. |
| 24. FUNERAL DIRECTOR NAME AND ADDRESS: Howard K. McComas III, Abingdon, Md. 21009 | | 25a. DATE REC'D. BY REGISTRAR: DEC 27 88 | 25b. REGISTRAR'S SIGNATURE: Lucia Davidson-Randall | | |

DHMH - 16 50M 1/81 (VRA 15, 4)

017468 DEC 21 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

(C)

REG. NO. 88 36307

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Henry | MIDDLE: E | LAST: Brown | 2a. DATE OF DEATH MONTH DAY YEAR: December 15 1988 | 2b. HOUR: 1240 AM | |
| 3. SEX: Male | 4. RACE: Black | 5. DATE OF BIRTH MONTH DAY YEAR: 3 23 21 | 6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD. | | |
| 10. CITY OR TOWN OF DEATH: Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Mem. Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Civil Service | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Harford | 13c. CITY OR TOWN: Havre de Grace | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET ADDRESS: 117 N. Stokes 21078 | |
| 14. FATHER'S NAME FIRST: Henry | MIDDLE: A. | LAST: Brown | 15. MOTHER'S MAIDEN NAME FIRST: Iola | MIDDLE: | LAST: Johnson |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes | (IF YES, GIVE WAR OR DATES): WW II | 16b. SOCIAL SECURITY NO.: 214-18-6008 | 17. INFORMANT: Lois Brown | ADDRESS: - same as above (wife) | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiogenic Shock — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b): Acute Myocardial Infarction

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c): Renal Failure, Prostate Ca

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12-1 19 88 to 12-15 19 88, that (I) (we) last saw the deceased alive on 12-13 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Andrew Nowakowski MD | DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED: 12/20/88 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): ANDREW NOWAKOWSKI MD | 22e. ADDRESS: 125 N. MAIN ST | BEL AIR, MD 21014 | |

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12-19-88 | 23c. NAME OF CEMETERY OR CREMATORY: United Union Swan Creek | 23d. LOCATION CITY OR TOWN: Aberdeen | COUNTY: Harford | STATE: MD |
| 24. FUNERAL DIRECTOR NAME: ARNOLD BEARD | ADDRESS: P.O. Box 188 Havre de Grace MD | 25a. DATE REC'D. BY REGISTRAR: DEC 21 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Registrar | | |

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

Item #'s 18a,21a,b,c,d,e,f 22a per med Film G649cg — Item13e,17 Film G6493/8/89cg

018532 JAN -9 93

FOR REGISTRAR 1- STATE UNKNOWN 88-170 3/3/89

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 6 8 0 3

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH KNOWN ☐ ESTIMATED XX MONTH | DAY | YEAR | 2b. HOUR |
|---|---|---|---|---|---|---|
| Byron | | Carr | 11 | 19 | 1988 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH | DAY | YEAR | 6. AGE (IN YEARS) LAST BIRTHDAY | IF UNDER 1 YR. MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN | 2c. DATE PRONOUNCED DEAD MONTH | DAY | YEAR | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | MAR. | 30, | 1948 | 40 YRS. | | | | | 12- | 29- | 19 88 | 6:45 P M |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| PENNSYLVANIA | USA | | Harford County MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| | Susquehanna River | ENGINEER | PHILA.ELEC.CO. |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS |
|---|---|---|---|---|
| PENNSYLVANIA | | PHILADELPHIA | | 812 ~~8112~~ SUSQUEHANNA RD. 19111 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| MARTIN | | CARR | DOLORES | | KORFF |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| NO | | 172-42-5151 | MRS. BEVERLY CARR 812 ~~8112~~ SUSQUEHANNA RD. PHILA., PA 19111 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Drowning — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☑ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | 11/19/1988 | Subject drowned |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | Bridge | I-95 Bridge | in Susquehanna River | Harford | Md. |

22a. I certify that I took charge of the remains described above, held an Autopsy XX Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☑ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE _____ TITLE (SPECIFY) ACTing Deputy Chief M.D. _____ MEDICAL EXAMINER DATE SIGNED 12-30-88

VC EXAMINER'S NAME (TYPE OR PRINT) Charles P. KOkes,M.D. ADDRESS 111 Penn Street,Baltilmore,MD 21201

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | COUNTY | STATE |
|---|---|---|---|---|---|
| REMOVAL/BURIAL | DEC.31,1988 | SHOLOM MEM. PARK | LOWER MORELAND | PA | |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| SOL LEVINSON & BROS., INC. | 6010 REISTERSTOWN RD. BALTO., MD 21215 | JAN 6 1989 | Julia Davidson-Randall |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP 250

DHMH - 17 (VR A15 ME (5))

017620 DEC 30 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 036809 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: PAULINE | Middle: L. | Last: CLARK | 2a. DATE OF DEATH Month: 12 Day: 14 Year: 88 | 2b. HOUR 2:40 A.M. | |
| 3. SEX: F | 4. RACE: B | 5. DATE OF BIRTH Month: 10 Day: 9 Year: 25 | 6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS. | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD | | |
| 10. CITY OR TOWN OF DEATH: HAVRE DE GRACE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HARFORD MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Harford | 13c. CITY OR TOWN: Aberdeen | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 31 Roosevelt Drive 2-F 21001 | |
| 14. FATHER'S NAME First: Robert | Middle | Last: Bowser | 15. MOTHER'S MAIDEN NAME First: Caroline | Middle | Last: Monk |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): N/A | 16b. SOCIAL SECURITY NO.: 212-28-5342 | 17. INFORMANT: Jennie Mae Elliott | ADDRESS: 40 E. Bel Air Ave. Aberdeen, Md. 21001 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio-pulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF (c): Severe Pneumonia - Mild stroke

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE | DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): ANTONIO H. CALON, M.D. | 22e. ADDRESS: 611 S. Union Ave, Havre de Grace, Md. 21078 | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/19/88 | 23c. NAME OF CEMETERY OR CREMATORY: Swan Creek Methodist | 23d. LOCATION CITY OR TOWN: Aberdeen | COUNTY: Harford STATE: Md. |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399 | 25a. DATE REC'D. BY REGISTRAR: DEC 16 88 | 25b. REGISTRAR'S SIGNATURE: Sicha Davidson-Randall | | |

BP 2

DHMH - 16 50M 1/81 (VRA 15, 4)

018048 JAN 14 88

STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36810
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. The medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR | |
| Edna | | Clary | 12-28-88 | 1:45 | PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| Female | Caucasian | 2/ 25/ 1900 | 88 YRS | | | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | | Harford County MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Belair | Belair Convelescent Center | Clerical State of MD | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Harford | Abington | YES ☐ NO ☒ | 113 Holly Wreath Road 21009 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Charles | F. | Smith | Anna | | Knierim |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | |
|---|---|---|---|---|
| No | ----- | 215-09-6728 | Mr. Charles Lambert | 1602 Kirkwood Road Baltimore, MD 21207 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Aspiratin Pneumnia | 3 weeks |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Cerebrovascular accident | 1 year |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Bedridden Status. | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| ☐ | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from August 19 88 to Dec 28 19 88, that (I) (we) last saw the deceased alive on 12-28 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Perfecto Vilarao | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12-28-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| PERFECTO VILARAO | 1716 Hanford Road, Fallston Md |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Burial | 12/30/88 | Western Cemetery | Baltimore City, MD |

| 24. FUNERAL DIRECTOR NAME ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Boring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 | DEC 30 1988 | Julia Davidson-Kemp |

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

14

018293 JAN 1 1989

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 513 3681 1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST: WALTER | MIDDLE: (nmn) | LAST: CLINE, JR. | 2a. DATE KNOWN OF DEATH [X] ESTIMATED [ ] MONTH DAY YEAR: 12-23-88 | 2b. HOUR: M |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Feb.13,1951 | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.: 37 | IF UNDER 1 YR. MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 12-23-88 | 2d. HOUR: 9:30P |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD. | | | |
| 10. CITY OR TOWN OF DEATH: Fallston | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Rt. 152 North of intersection165 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerk | 12b. KIND OF BUSINESS OR INDUSTRY: USGovt- | | | |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Harford | Edgewood | YES [ ] NO [X] | 1914 Juniper Road, 21040 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Walter | (nmn) | Cline, Sr. | Anna | Marie | Jackson |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | none | 213-60-5755 | Roger W.Cline, 3501 N.Furnace Road | Jarrettsville,Md. 21084 |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple injuries
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
8121
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: 12-88 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10 PART 1 OR PART 2): a car passenger in/head-on collision with a pick-up truck |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): hgwy. | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE: Rt. 152 N. of intersection 165 / Harford Co.,Md |

22a. I certify that I took charge of the remains described above, held an Autopsy [XX], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Margarita Korell M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED: 12-24-88

EXAMINER'S NAME (TYPE OR PRINT): Margarita A. Korell,M.D. ADDRESS: 111 Penn Street

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec.27,1988 | Bel Air Memorial Gardens, | Bel Air Harford Md. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Howard K. McComas III,Abingdon,Md. 21009 | DEC 27 '88 | Julia Davidson-Randall |

BP

DHMH - 17
(VR A15 ME (5))

018881 JAN 11 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 36812

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT): FIRST Mary MIDDLE E. LAST Collins

2a. DATE OF DEATH: MONTH Dec. DAY 28, YEAR 1988

2b. HOUR 9:30 A.M.

3. SEX: Female

4. RACE: Negro

5. DATE OF BIRTH: MONTH Sept. DAY 22, YEAR 1899

6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Domestic

12b. KIND OF BUSINESS OR INDUSTRY: P.T. Family

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Harford

13c. CITY OR TOWN: Aberdeen

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 641 Elm St. 21001

14. FATHER'S NAME: FIRST Daniel MIDDLE (S) LAST Webster Sr.

15. MOTHER'S MAIDEN NAME: FIRST Mamie MIDDLE ? LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES): 220-14-0795

17. INFORMANT: Edgar C. Collins ADDRESS 641 Elm St. Aberdeen, Md 21001

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Heart Disease

DUE TO, OR AS A CONSEQUENCE OF (c): ARTERIOSCLEROSIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/28 19 88 to 12/28 19 88, that (I) (we) last saw the deceased alive on 12/28 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Dante U. Monakir DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12/29/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DANTE U. MONAKIR

22e. ADDRESS: Havre de Grace, Md 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Dec. 31-88

23c. NAME OF CEMETERY OR CREMATORY: Union United Meth Cem

23d. LOCATION CITY OR TOWN: Aberdeen COUNTY: Harford STATE: Md.

24. FUNERAL DIRECTOR NAME: Otelia J. Bullock ADDRESS: 556 Lewis St Havre de Grace Md 21078

25a. DATE RECD. BY REGISTRAR: DEC 30 88

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 2

DHMH - 10-50M 1/81 (VSA 15, 4)

018882 JAN 11 88 — FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 036813 — REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once!

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST | Jesse Ray Comer | | | 2a. DATE OF DEATH — MONTH DAY YEAR | 12 28 88 |
| | | | | 2b. HOUR | 9:25 AM |
| 3. SEX | male | 4. RACE | white | 5. DATE OF BIRTH — MONTH DAY YEAR | 10 04 25 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 63 YRS. | IF UNDER 1 YEAR — MONTHS / DAYS | | IF UNDER 24 HRS. — HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Virginia | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Harford MD. | | | | |
| 10. CITY OR TOWN OF DEATH | Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Fallston General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Ret. Govt. Employee A.P.G. |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Maryland | 13b. COUNTY | Harford | 13c. CITY OR TOWN | Churchville |
| 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | | 13e. STREET ADDRESS | 600 Priestford Rd. 21028 | | |
| 14. FATHER'S NAME — FIRST / MIDDLE / LAST | Garnett Comer | 15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST | Bertha Goss | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | No | (IF YES, GIVE WAR OR DATES) | N/A | 16b. SOCIAL SECURITY NO. | 220-22-0278 |
| 17. INFORMANT — ADDRESS | Mrs. Edith E. Comer, Same as above | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Congestive Cardiomyopathy | mths |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Ischemic Heart Disease | years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | ASCVD | years |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | B Vassar | DEGREE — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED 12/29/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | DEAN L. VASSAR. | 22e. ADDRESS | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION — CITY OR TOWN / COUNTY / STATE | |
| Burial | 12/30/88 | Churchville Presby. | Churchville | Harford Md. |
| 24. FUNERAL DIRECTOR — NAME / ADDRESS | Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399 | 25a. DATE REC'D. BY REGISTRAR | DEC 30 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall |

DHMH - 16 50M 1/81 (VRA 15, 4)

017147 DEC 27 '88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 36814

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Mary | MIDDLE: Carolyn | LAST: Connors | 2a. DATE OF DEATH MONTH DAY YEAR: 12 - 19 - 88 | 2b. HOUR: 1:30 AM | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: October 6, 1931 | 6. AGE (IN YEARS LAST BIRTHDAY): 57 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD. | | |
| 10. CITY OR TOWN OF DEATH: Bel Air | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Bel Air Convalescent Center | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Baltimore | 13c. CITY OR TOWN: Parkton | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS / ZIP CODE: 1301 Armacost Road 21120 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST: George Moore Brown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Wilhelmina Amalia Habicht | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 211-26-3805 | 17. INFORMANT ADDRESS: Lynn Rosier 1301 Armacost Road, Parkton, Md. 21120 | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac pulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF: (b): Congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF: (c): Diabetes
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from Oct 19 88 to Dec 19 88, that (I) (we) last saw the deceased alive on Dec 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 12/19/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): LINDA TREICH 22e. ADDRESS: 1 Bel Church Lane, Bel Air, Md.

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Dec. 21, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: Ayres Chapel United Meth. Ch. Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Norrisville, Md. | |
| 24. FUNERAL DIRECTOR NAME: Hartenstein-Orsburn Funeral Home | ADDRESS: 19 S. Main St. Stewartstown, Pa. | 25a. DATE REC'D BY REGISTRAR: DEC 23 1988 | 25b. REGISTRAR'S SIGNATURE: Sylvia Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84 (VRA 15, 4)

017395 DEC 28 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36815
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the case.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST | Walter / W. / Dietz Sr. | 2a. DATE OF DEATH — MONTH DAY YEAR | 12 - 21 - 88 | 2b. HOUR | 3 10 AM |
| 3. SEX | Male | 4. RACE | White | 5. DATE OF BIRTH — MONTH DAY YEAR | Sept. 2, 1917 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 71 YRS | # UNDER 1 YEAR — MONTHS / DAYS | | # UNDER 24 HRS — HOURS / MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Maryland | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Harford County MD. | | | | |
| 10. CITY OR TOWN OF DEATH | Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Fallston General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Farmer |
| 12b. KIND OF BUSINESS OR INDUSTRY | Self -Employed | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Md. | 13b. COUNTY | Baltimore | 13c. CITY OR TOWN | Kingsville |
| 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | | 13e. STREET ADDRESS | 12115 Stoney Batter Rd. 21087 | | |
| 14. FATHER'S NAME — FIRST / MIDDLE / LAST | Gottlieb / / Dietz | 15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST | Katherine / / Wolfe | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | yes | IF YES, GIVE WAR OR DATES | 1945-1946 | 16b. SOCIAL SECURITY NO. | 217-12-8334 |
| 17. INFORMANT | Mrs. Esther J. Dietz, | ADDRESS | 12115 Stoney Batter Kingsville, Md. 21087 | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE

DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CHRONIC OBSTRUCTIVE LUNG DISEASE + CHF

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ] | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/12 19 88 to 12/21 19 88, that (I) (we) last saw the deceased alive on 12/21 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Dante M. Monakil | DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED 12/21/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | DANTE M. MONAKIL | 22e. ADDRESS | Havre de Grace Md 21078 |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Burial | 23b. DATE | 12-23-1988 | 23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gar. |
| 23d. LOCATION CITY OR TOWN / COUNTY / STATE | Bel Air / Harford / Md. | | | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087 | 25a. DATE REC'D BY REGISTRAR | DEC 27 1988 | 25b. REGISTRAR'S SIGNATURE |

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

016447 DEC 15 88 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 6 8 1 6

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Larry | June | Dixon Jr. | 12-11 19 88 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS) LAST BIRTHDAY | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| Male | white | July 16, 1972 | 16 YRS. | | | 12-11 19 88 | 5:00 p. M |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Balto. Co.Md. | U.S.A. | | Harford County, MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Whiteford | Rt. 136 | Student | N.Harford high |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Harford | Street | YES ☐ NO ☒ | 1519 Robinson Rd. 21154 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Larry | J. | Dixon Sr. | Martha | J. | Smith |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| ------ | 219-11-4736 | Martha Hudson, 1519 Robinson Mill Rd. Street, Md. 21154 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multiple Injuries

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES XX NO ☐ |

| 21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR XXX MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | 3:00 P.M. 12-11 19 88 | passenger in van/pick-up truck impact |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
|---|---|---|
| | highway | Rt. 136, Harford Co., Maryland |

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE John E. Smialek M.D. TITLE (SPECIFY) M.D. Chief MEDICAL EXAMINER DATE SIGNED 12-12-88

EXAMINER'S NAME (TYPE OR PRINT) John E. Smialek, M.D. ADDRESS 111 Penn St., Balto., Md. 21201

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Burial | 12-15-1988 | Holly Hill Cemetery | Middle River Balto. Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Lochary Funeral Home | 11750 Belair Rd. Kingsville, Md. 21087 | DEC 14 1988 | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

018647 JAN 10 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36817 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before

BP 3

DHMH - 1650M 1/81 (VRA 15, 4)

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: William MIDDLE: J. LAST: Donahue, SR | | 2a. DATE OF DEATH MONTH DAY YEAR: 12-17-88 | 2b. HOUR: 9:50 P M |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: 3 22 1903 | 6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS. — IF UNDER 1 YEAR MONTHS / DAYS; IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD. |
| 10. CITY OR TOWN OF DEATH: Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Restauranter | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md. | 13b. COUNTY: Cecil | 13c. CITY OR TOWN: Rising Sun | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ |
| 13e. STREET ADDRESS: 7 Brinker Ct. 21911 | | | |
| 14. FATHER'S NAME FIRST: James MIDDLE LAST: Donahue | | 15. MOTHER'S MAIDEN NAME FIRST: Sarah MIDDLE LAST: O'Connor | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): — | 16b. SOCIAL SECURITY NO.: 100-01-5747 | 17. INFORMANT: Wm. Donahue, JR | ADDRESS: 7 Brinker Court Rising Sun MD |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | old age (85 yrs) | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | ASCVD & nephropathy | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Cataract | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12-10, 1988, to 12-17, 1988, that (I) (we) last saw the deceased alive on 12-17, 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: John D Yun | DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | | 22c. DATE SIGNED: 12/18/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOHN D YUN | | 22e. ADDRESS: Havre de Grace, MD | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12-21-88 | 23c. NAME OF CEMETERY OR CREMATORY: Brookview Cem | 23d. LOCATION CITY OR TOWN: Rising Sun | COUNTY: Cecil STATE: MD |
| 24. FUNERAL DIRECTOR NAME: R.T. Foard Funeral Home ADDRESS: Rising Sun MARYLAND | | 25a. DATE REC'D. BY REGISTRAR: DEC 22 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

017154 DEC 27

1 - FOR STATE REGISTRAR

REG. NO. 88 036818

1. DECEASED NAME (TYPE OR PRINT): Gavin Lee Dowling
2a. DATE OF DEATH: December 21 1988
2b. HOUR: 6 AM/M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: June 19 1984
6. AGE (IN YEARS LAST BIRTHDAY): 4 YRS
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington D.C. U.S.A.
7b. CITIZEN OF WHAT COUNTRY?
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.
10. CITY OR TOWN OF DEATH: Havre de Grace
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Harford
13c. CITY OR TOWN: Aberdeen
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: 2788 - A Dolphin Court 21005

14. FATHER'S NAME: Edward A. Dowling
15. MOTHER'S MAIDEN NAME: Ruth Ann Koenig
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
16b. (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS: Jack Koenig 2803 Bluebird Ave., Hagerstown

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): RESPIRATORY FAILURE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b): BRONCHOSPASM / INFECTION
DUE TO, OR AS A CONSEQUENCE OF (c): ASTHMA —
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): MULTIPLE CONGENITAL MALFORMATIONS.

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from DEC 14, 1988, to DEC 21, 1988, that (I) (we) last saw the deceased alive on DEC 21, 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE
DEGREE: M.D.
ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/21/88.
22d. PHYSICIAN'S NAME (TYPE OR PRINT): ALONSO GOMEZ M.D.
22e. ADDRESS: HARFORD MEMORIAL HOSPITAL, HAVRE DE GRACE MD. 21078.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Dec. 23, 1988
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION CITY OR TOWN / COUNTY / STATE: Hagerstown Washington Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: MINNICH FUNERAL HOME, 415 E. Wilson Blvd., Hagerstown, Maryland 21740
25a. DATE REC'D. BY REGISTRAR: DEC 23 1988
25b. REGISTRAR'S SIGNATURE: Erika Davidson-Kendall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

Item #'s 18a,part2 22aFilm G648 per med 2/3/89 dg

FOR 1- STATE REGISTRAR

0J8395 JAN 9 89

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 6 8 1 9

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST: Betty | MIDDLE: Ann | LAST: Dyer | 2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ | MONTH: 11 | DAY: 19 | YEAR: 88 |
| 2b. HOUR | | | | | | | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: July 14, 1932 | 6. AGE (IN YEARS LAST BIRTHDAY): 56 YRS. | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN | 2c. DATE PRONOUNCED DEAD: 12-9- 88 | 2d. HOUR: 4:00P M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD. | | | | |
| 10. CITY OR TOWN OF DEATH: BALDWIN | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 3116 Moores Road 21013 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): REGESTERED NURSE | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE: MD. | 13b. COUNTY: Harford | 13c. CITY OR TOWN: Baldwin | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 3116 Moores Rd.21013 | | | |
| 14. FATHER'S NAME: FIRST Robert | MIDDLE | LAST Hand | 15. MOTHER'S MAIDEN NAME: FIRST Rose | MIDDLE | LAST Unknown to Records | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 219-28-8411 | 17. INFORMANT: J.Roxanne Lawhon | ADDRESS: Terra Vista Dr. Baldwin,Md. | | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

Chronic alcoholism

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☒ NO ☐ |
| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Charles P. Kokes

TITLE (SPECIFY): Acting Deputy Chief M.D. MEDICAL EXAMINER

DATE SIGNED: 12-10-88

VC EXAMINER'S NAME (TYPE OR PRINT): Charles P. KOkes,M.D. ADDRESS: 111 Penn Street,Baltimore,MD 21201

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION | 23b. DATE: 12/31/1988 | 23c. NAME OF CEMETERY OR CREMATORY: SECURITY PROCESS | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: CATONSVILLE BALTO. MD. |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: CREMATION SOCIETY OF MD, 299 FREDERICK RD. | 25a. DATE REC'D. BY REGISTRAR: JAN 6 1989 | 25b. REGISTRAR'S SIGNATURE: Gina Saunderson Rankin | |

BP 245

DEMH - 17
(10) A15 ME (5))

017273 DEC 27 88 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36820 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH | DAY | YEAR | 2b. HOUR |
| Beatrice | P. | Elsner | Dec. | 5, | 1988 | 11:57 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH | DAY | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS HOURS | MIN. |
|---|---|---|---|---|---|---|---|---|---|
| Female | White | 10 | 23 | 04 | 84 YRS | | | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | | Harford MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Havre de Grace | Harford Memorial Hospital | Ret. Civil Service | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Harford | Havre deGrace | YES ☐ NO ☒ | 4033 Webster Rd. 21078 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Arthur | | Preston | Cecelia | | Grice |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | N/A | 212-22-5071 | W. Arthur Elsner Jr., | Same as above |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Embolism — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1dy

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Mural Cardiac Thrombosis

DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heartdisease Coronary Atherosclerosis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Irvin L. Wachsman | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/6/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Irvin L Wachsman | S. Union Ave; Havre de Grace MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | 12/8/88 | Baker Cemetery | Aberdeen | Harford | Md. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399 | DEC 09 88 | Evelyn Davidson-Kendall |

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

0171146 DEC 27 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 88 036821

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Gladys | MIDDLE: V. | LAST: Evans | 2a. DATE OF DEATH KNOWN XX ESTIMATED ☐ MONTH DAY YEAR: 12-20-88 | 2b. HOUR: M | | | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: May 31,1907 | 6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS. | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 12-20-88 | 2d. HOUR: 5:22A M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD. | | | | |
| 10. CITY OR TOWN OF DEATH: Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Harford | 13c. CITY OR TOWN: Street | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 3530 Prospect Road 21154 | | | |
| 14. FATHER'S NAME FIRST: Gilbert | MIDDLE: | LAST: Hinton | 15. MOTHER'S MAIDEN NAME FIRST: Carrie | MIDDLE: | LAST: Bogart | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 218-28-6394 | 17. INFORMANT: Joe D. Evans | ADDRESS: 3530 Prospect Road Street, Maryland | | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Fracture of left pelvis and left hymerus

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES XX NO ☐ |
| 21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: 12-20-88 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Subject fell |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): nursing home | 21f. LOCATION STREET: Citizens Nursing Home CITY OR TOWN: Havre de Grace COUNTY: Harford STATE: County, MD |

22a. I certify that I took charge of the remains described above, held on Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Margarita A. KOrell M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED: 12-20-88

VC EXAMINER'S NAME (TYPE OR PRINT): Margarita A. KOrell,M.D. ADDRESS: 111 Penn Street,Baltimore,MD 21201

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | 12-22-88 | Valley View | Montdale | Lackawana | PA |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Harkins Funeral Home,Inc. | 600 Main Street Delta, PA 17314 | DEC 23 1988 | Julia Davidson-Randall |

DHMH - 17
(VR A15 ME (5))

0161 50 DEC 14 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

88 036822 REG. NO.

AKA: Harry T.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| TEUNES | | EYGENRAAM | 12 8 1988 | 7:15 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Male | Caucasian | April 3, 1900 | 88 yrs. YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| therlands | USA | | HARFORD COUNTY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| HAVRE DE GRACE | CITIZENS NURSING HOME | Table Splicer | Steel Co. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Md. | Harford | Street | YES ☐ NO ☒ | 3214 Sandy Hook Road 21154 |

| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |
|---|---|
| Peter Eygenraam | Maria Hoogerroerf |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | -- | 216-72-2567 | Catherine Rose | Same Address as above |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Anemia

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 11/1 19 88 to 12/8 19 88, that (I) (we) last saw the deceased alive on 12/8 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Dante Monakil | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/9/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DANTE MONAKIL | Havre de Grace, Md 21078 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Cremation | 12-9-88 | Security Process | Balto., Md. |

| 24. FUNERAL DIRECTOR NAME ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Schimunek Funeral Home, Inc. 9705 Belair Road, Balto., Md. 21236 | DEC 13 1988 | Julia Davidson-Landeen |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is checked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

017763 DEC 30 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 368223 REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH | DAY | YEAR | 2b. HOUR |
|---|---|---|---|---|---|---|
| SCOTT | McKINLEY | FURCHES | 12 | 12 | 88 | 7:25a M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH, DAY, YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Male | White | April 8, 1898 | 90 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Tennessee | USA | | HARFORD MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| HARVE de GRACE | CITIZENS NURSING HOME | Custodian | US-govt.Ret. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Harford | Bel Air | YES ☐ NO ☒ | 4330 Old Philadelphia Road Bel Air, Md. 21014 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| James | Alexander | Furches | Nancy | Emeline | Hudgins |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | none | 410-01-0042 | Bina E. Younce, 4330 Old Philadelphia Road | Bel Air, Md. 21014 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Old age — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) Amputation of rt. foot

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE John D Yun DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 12/12/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN D YUN — 22e. ADDRESS Havre de Grace, MD

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec. 15, 1988 | Mountain Christian Cem. | Joppa / Harford / Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Howard K. McComas III | Abingdon, Md. 21009 | DEC 13 88 | Gina Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21a is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 16 50M 4/83
(VRA 15, 4)

016572 DEC 1988

STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

58 36821
REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|---|
| Robert | Robert | (nmn) | Gottschalk | 12 2 88 | 11:45 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
|---|---|---|---|---|---|
| Male | White | 12 17 13 | 74 Y YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| New York | USA | | Harford County MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Fallston | Fallston General Hospital | Service Technician | Electric |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| N.J | Bergen | Englewood | YES ☐ NO ☒ | 25 Sheffield 07631 |

| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME |
|---|---|
| Mendez Gottschalk | Ellen Sweeney |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | IF YES, GIVE WAR OR DATES | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | none | 145-01-1340 | John Beward, 1560 Harford Square Drive | Edgewood, Md. 21040 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiac Arrest | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Coronary Art dis | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).
Prev M.I.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 11 26 19 88 to 12/2 19 88 that (I) (we) last saw the deceased alive on 19 88 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|---|
| | M.D. | | |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| V. S. Nair MD | 2112 Belair Road. Dallas MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Cremation | Dec. 6, 1988 | Cedar Lawn Crematory | Patterson | Passaic | N.J. |

| 24. FUNERAL DIRECTOR | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Howard K. McComas III, Abingdon, Md. 21009 | DEC 05 '88 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-916 (MM 7/84) (VRA 15-4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 036825

1. DECEASED NAME (TYPE OR PRINT): FIRST Nellie MIDDLE J. LAST Green
2a. DATE OF DEATH: MONTH 12 DAY 11 YEAR 88
2b. HOUR 5 20 A M
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: MONTH OCTOBER DAY 19 YEAR 1902
6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.
10. CITY OR TOWN OF DEATH: Havre de Grace
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: HARFORD
13c. CITY OR TOWN: HAVRE de GRACE
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 968 CHESAPEAKE DRIVE 21078

14. FATHER'S NAME: FIRST WILLIAM MIDDLE THOMAS LAST PRESTON
15. MOTHER'S MAIDEN NAME: FIRST JOSEPHINE MIDDLE LAST HIPKINS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
(IF YES, GIVE WAR OR DATES):
16b. SOCIAL SECURITY NO.: 212 52 8527
17. INFORMANT: LYTTLETON S. GREEN, SON, SAME AS #13e ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Rupture of aneurysm of thoracic aorta — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD, c aortic insufficiency
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Brian T. Yeo DEGREE M.D ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12DEC88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): BRIAN T. YEO, M.D.
22e. ADDRESS: UNION AVENUE, HAVRE de GRACE, MD 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: 14 DEC 1988
23c. NAME OF CEMETERY OR CREMATORY: ANGEL HILL CEMETERY
23d. LOCATION CITY OR TOWN: HAVRE de GRACE COUNTY: HARFORD CO., STATE: MD
24. FUNERAL DIRECTOR NAME AND ADDRESS: MITCHELL-SMITH FUNERAL HOME PA, HAVRE de GRACE, MD 21078
25a. DATE REC'D. BY REGISTRAR: DEC 13 1988
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page # may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81 (VRA 15, 4)

018883 JAN 11 89 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36826 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Wethelmina MIDDLE: E. LAST: Hadry | | 2a. DATE OF DEATH MONTH: Dec DAY: 28, YEAR: 1988 | 2b. HOUR: 11:05 P M |
| 3. SEX: Female | 4. RACE: white | 5. DATE OF BIRTH MONTH: MAY DAY: 23, YEAR: 1905 | 6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS. IF UNDER 1 YEAR MONTHS: DAYS: IF UNDER 24 HRS HOURS: MIN.: |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD. |
| 10. CITY OR TOWN OF DEATH: Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hosp | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER | 12b. KIND OF BUSINESS OR INDUSTRY: |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md. | 13b. COUNTY: Harford | 13c. CITY OR TOWN: Havre de Grace | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ |
| 13e. STREET ADDRESS: 505 Congress Ave. #103 21078 | | | |
| 14. FATHER'S NAME FIRST: FRANCIS MIDDLE: LAST: MERGLER | | 15. MOTHER'S MAIDEN NAME FIRST: LILLIE MIDDLE: LAST: FADLEY | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 219-16-7045 | 17. INFORMANT ADDRESS: MERRILL HADRY, 609 E. WINDING HILL RD, MECHANICSBURG PA 17055 | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): AS OF CHF
DUE TO, OR AS A CONSEQUENCE OF (c): Anemia, Renal failure

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12-28, 19 88 to 12-28, 19 88, that (I) (we) last saw the deceased alive on 12-28 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: T Lee | DEGREE: M.D. | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12/29/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): T. Lee | 22e. ADDRESS: Linton Med Clinic | | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: 31DECEMBER88 | 23c. NAME OF CEMETERY OR CREMATORY: ANGEL HILL CEMETERY | 23d. LOCATION CITY OR TOWN: HAVRE de GRACE, COUNTY: HARFORD CO., STATE: MD |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: MITCHELL-SMITH FUNERAL HOME PA, HAVRE de GRACE, MD 21078 | 25a. DATE REC'D BY REGISTRAR: DEC 30 '88 | 25b. REGISTRAR'S SIGNATURE: Lia Davidson-Randall | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

BP 60

DHMH - 1650M 1/81 (VRA 15, 4)

HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

0 1 8 2 3 9 JAN -6 89 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

89 036827
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: PETE | MIDDLE | LAST: HAGEGEORGE | 2a. DATE OF DEATH MONTH: 1 DAY: 01 YEAR: 89 | 2b. HOUR: 5 35 M | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: 9-4-1927 | 6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD. | | |
| 10. CITY OR TOWN OF DEATH: Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Paper Carrier | 12b. KIND OF BUSINESS OR INDUSTRY: A.S. Abell | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Harford | Fallston | YES [ ] NO [X] | 1303 Grandview Ct. 21047 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| George / / Hagegeorge | Anna / / Balas |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| Yes | WWII | 218-26-1554 | Thelma Hagegeorge, Same as 13e |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Cerebral Bleeding with intraventricular extension — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 48 hrs
DUE TO, OR AS A CONSEQUENCE OF
(b): Hypertensive - ASCVD. - Old MI - Tachyarrhythmia
DUE TO, OR AS A CONSEQUENCE OF
(c): Diabetes Mellitus - PUD by Hx.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cerebral Cortical atrophy - Alzheimer's - Old Cerebral infarct (2)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 12/30/88 to 1/1/89, that (I) (we) last saw the deceased alive on 11/11/88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | 22c. DATE SIGNED |
|---|---|---|---|---|
| D. L. Pirovolidis | MD | ATTENDING PHYSICIAN [ ] | MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 1/1/89 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| D. L. PIROVOLIDIS | 212 S. Bond St. Bel Air Md. 21014 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 1-4-89 | Greek Orthodox | Balto., Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Leonard J. Ruck, Inc., | 5305 Harford Rd., Balto., Md. 21214 | JAN 5 1989 | |

BP_____

DHMH - 1650M 1/81
(VRA 15, 4)

016632 DEC 19 88

FOR 1 - STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

REG. NO 88 036828

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Mary Middle: Ruth Last: Hall | | | 2a. DATE OF DEATH Month Day Year: 11 29 88 | 2b. HOUR: 10:53 A.M. | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH Month Day Year: June 4, 1913 | 6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD. | | |
| 10. CITY OR TOWN OF DEATH: HAVRE DE GRACE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HARFORD MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: -- | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Harford | Havre de Grace | YES ☐ NO ☒ | 505 Congress Ave. Apt. 201 21078 |

| 14. FATHER'S NAME First Middle Last | 15. MOTHER'S MAIDEN NAME First Middle Last |
|---|---|
| Luther Estel Quillen | Eula Mae Walton |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| no | -- | 219-34-1585 | Noble W.Hall, 3915 Conowingo Rd., Darlington Md. 21034 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:

| | | Approximate interval between onset and death |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiac Failure | 3 dys |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Massive myocardial infarction | 3 dys |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Hypertensive arteriosclerotic Heart disease | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☑ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| ☐ | | |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | | |

22a. I certify that (I) (this hospital) attended the deceased from ____ 19____, to ____ 19____, that (I) (we) last saw the deceased alive on ____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Irvin H. Wachsman | MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐ | 11/28/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| IRVIN H. WACHSMAN | 501 South Union Ave. Hav de Grace Md 21078 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec. 1, 1988 | Franklin Baptist Cem. | Darling Harford Md. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Howard K. McComas III, Abingdon, Md. 21009 | DEC 01 '88 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5+1

DHMH - 16 50M 1/81 (VRA 15, 4)

19614 JAN 18 89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36829 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Clifford | MIDDLE: B | LAST: Himes SR | 2a. DATE OF DEATH MONTH: 12 DAY: 30 YEAR: 88 | 2b. HOUR: 12 04 P M | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH: 8 DAY: 4 YEAR: 11 | 6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS. | IF UNDER 1 YEAR MONTHS: DAYS: | IF UNDER 24 HRS HOURS: MIN.: |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD. | | |
| 10. CITY OR TOWN OF DEATH: FALLSTON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): (RET) SELF-EMPLOYED | 12b. KIND OF BUSINESS OR INDUSTRY: SERVICE STATION | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | HARFORD | HAVRE de GRACE | YES [ ] NO [X] | 4012 ROCK RUN ROAD, 21078 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| ROBERT | HENRY | HIMES | LILLIE | MAE | STEVENSON |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 217 03 3209 | SARA BOWMAN HIMES, WIFE | SAME AS #13e |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Congestive Heart Failure | 6 months |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Ischemic Heart Disease | Years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Renal failure chronic acute | 2 months |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Acute Myocardial Infarction 1 week

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 12-17, 19 88, to 12-30, 19 88, that (I) (we) last saw the deceased alive on 12-30, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Perfecto C. Valarao | MD | ATTENDING PHYSICIAN [X] | MEDICAL DIRECTOR [ ] | STAFF PHYSICIAN [ ] | 12-30-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| PERFECTO C. VALARAO | 1716 HARFORD Rd, FALLSTON MD 21047 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 3JANUARY89 | ROCK RUN CEMETERY | ROCK RUN, HARFORD COUNTY, MD |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE RECD. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| MITCHELL-SMITH FUNERAL HOME PA, HAVRE de GRACE, MD 21078 | JAN 04 89 | Julia Davidson-Randall |

BP 10

DHMH - 1650M 1/81 (VRA 15, 4)

016213 DEC 15 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 6 3 3 0

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH KNOWN [XX] ESTIMATED [ ] MONTH | DAY | YEAR | 2b. HOUR |
| Agnes | A. | Holloway | 11 | 24 | 1988 | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR |
| Female | White | Dec. 13 1901 | 86 YRS. | | | 11 24 1988 |
| 2d. HOUR: 8:10A M | | | | | | |

| | | | |
|---|---|---|---|
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH |
| Maryland | United States | | Harford County MD. |

| | | | |
|---|---|---|---|
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| Havre de Grace | Harford Memorial Hospital | Homemaker | Own home |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET ADDRESS |
| Maryland | Harford | Darlington | | 1315 Stafford Road/21034 |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | |
| Harmon Clinton Scarborough | Grace Kelly | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
| No | ---------- | 217-50-2194 | Clifford W. Holloway 1315 Stafford Rd Darlington, MD |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic vascular disease complicating Left hip fracture

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

8842

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [XX] NO [ ] |
| | | |

| | | |
|---|---|---|
| 21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| | Unk 11/10 1988 | fell getting out of bed |

| | | |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] XX | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| | Home | 1315 Stafford Rd, Darlington, HarfordCo., MD |

22a. I certify that I took charge of the remains described above, held an Autopsy [XX] Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [XX] Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE [signature] TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 11/25/88

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn Street, Balto, MD 21201

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | 11/27/88 | Darlington Cemetery | Darlington Harford MD |

| | | |
|---|---|---|
| 24. FUNERAL DIRECTOR NAME ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| Harkins Funeral Home 600 Main Street Delta, PA | NOV 29 1988 | [signature] |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

018884 JAN

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 036831

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: JIMMIE | MIDDLE: L. | LAST: HURST | 2a. DATE OF DEATH MONTH DAY YEAR: 12 29 88. | 2b. HOUR: 8:16 A. M. | |
| 3. SEX: M | 4. RACE: B | 5. DATE OF BIRTH MONTH DAY YEAR: 12 26 [illegible]20 | 6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Alabama | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD. | | |
| 10. CITY OR TOWN OF DEATH: HAVRE DE GRACE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HARFORD MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Truck Driver | 12b. KIND OF BUSINESS OR INDUSTRY | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Harford | Havre deGrace | YES ☒ NO ☐ | 440 Battery Drive 21078 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Tommy / HURST | Maggie / UNK |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| Yes | Korea | 417-20-9195 | Ada Hayden, Same as above |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Death on Arrival, acute MI suspected

DUE TO, OR AS A CONSEQUENCE OF (b): CHF.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c): HTN & ASCVD

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 12/28/88 to 12/29/88, that (I) (we) last saw the deceased alive on 12/29/88 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE / DEGREE | 22c. DATE SIGNED |
|---|---|
| Hong Jun Kim, M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/29/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| HONG JUN KIM. | UNION MEDICAL GROUP |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 1/3/89 | Angel Hill Cemetery | Havre de Grace, Harford Md. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399 | DEC 30 '88 | Julia Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RBP 1 of 1

DHMH 16 50M 1/81 (VRA 15, 4)

5P

019017 JAN 13 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36832
REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: RUTH | MIDDLE | LAST: JACKSON | 2a. DATE OF DEATH MONTH: 11 DAY: 30 YEAR: 88 | 2b. HOUR: 12:40 P.M. | |
| 3. SEX: F | 4. RACE: BLACK | 5. DATE OF BIRTH MONTH: 1 DAY: 13 YEAR: 26 | 6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD. | | |
| 10. CITY OR TOWN OF DEATH: HAVRE DE GRACE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HARFORD MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Domestic | 12b. KIND OF BUSINESS OR INDUSTRY | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Harford | Havre de Grace | YES ☒ NO ☐ | 122 Vancheria Ct. 21078 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|---|---|
| George Bond | Mary Jackson | No | 212-26-5026 | Andrew Sprouill 449 Village Dr HDG |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio - pulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Uremia DM
DUE TO, OR AS A CONSEQUENCE OF (c): Nephritis + Cardiac Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| [signature] | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12-2-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| ANTONIO H. CALON, MD | 611 S. Union Ave. Havre de Grace MD 21078 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12-5-88 | ST JAMES | Havre de Grace Harford MD |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Arnold Beres Inc. Box 188 Havre de Grace MD | DEC 12 1988 | [signature] Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR — Charles M. Jannke — REG. NO. 88 036833

5953 DEC 13 88

DECEASED NAME (TYPE OR PRINT): FIRST Charles MIDDLE M LAST Jannke

7a. DATE OF DEATH: MONTH December DAY 5 YEAR 1988 (12/5/88)

7b. HOUR 2:32 PM

3. SEX: Male

4. RACE: Caucasian

5. DATE OF BIRTH: MONTH Sept. DAY 13 YEAR 1936

6. AGE (IN YEARS LAST BIRTHDAY): 52 YRS

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD.

10. CITY OR TOWN OF DEATH: Fallston

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Forklift Opr.

12b. KIND OF BUSINESS OR INDUSTRY: Western Elec.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Baltimore

13c. CITY OR TOWN: Phoenix

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 14008 Sunnybrook Rd, 21131

14. FATHER'S NAME: FIRST J. Maurice MIDDLE LAST Jannke

15. MOTHER'S MAIDEN NAME: FIRST Agnes MIDDLE Irwin LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES): --

16b. SOCIAL SECURITY NO.: 212-36-1833

17. INFORMANT ADDRESS: Rt 2, Box 391, Picayune, Miss.

INFORMANT: Robert C. Creswell, Cousin,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hepatorenal Syndrome

DUE TO, OR AS A CONSEQUENCE OF (b): E. Coli Sepsis / Peritonitis

DUE TO, OR AS A CONSEQUENCE OF (c): Severe Alcoholic Hepatitis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hrs Days or Mos

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Acute Hepatitis Failure, Cachexia

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): N/A

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/14/88 to 12/5/88, that (I) (we) last saw the deceased alive on 12/5/88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: MMD — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12/6/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): LAZATIN MANUEL

22e. ADDRESS: 8 [illegible] Aberdeen, MD 21001

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: Dec. 10, 1988

23c. NAME OF CEMETERY OR CREMATORY: Chestnut Grove Presbyterian, Jacksonville, Md.

23d. LOCATION: CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR NAME: SCHIMUNEK FUNERAL HOME

ADDRESS: 9705 Belair Rd, Balto, Md. 21236

25a. DATE REC'D BY REGISTRAR: DEC 09 1988

25b. REGISTRAR'S SIGNATURE: Julia Tinsdon-Landers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

018265 JAN 89

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 6 8 3 4

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DHMH 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT): FIRST WILLIAM MIDDLE CALVIN LAST JONES
2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ MONTH DAY YEAR 19
2b. HOUR
3. SEX: M
4. RACE: W
5. DATE OF BIRTH: MONTH 2 DAY 17 YEAR 29
6. AGE (IN YEARS LAST BIRTHDAY): 59 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 29 YEAR 1988
2d. HOUR: 8:30 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD.
10. CITY OR TOWN OF DEATH: Aberdeen
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 11 Chesapeake Ct.
12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Supervisor
12b. KIND OF BUSINESS OR INDUSTRY: Construction
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: Harford
13c. CITY OR TOWN: Aberdeen
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 11 Chesapeake Ct 21001
14. FATHER'S NAME: FIRST John MIDDLE Harold LAST Jones
15. MOTHER'S MAIDEN NAME: FIRST Della MIDDLE Mae LAST McDaniels
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 215-28-4900
17. INFORMANT: Daughter ADDRESS: Robin J. Campbell 501 Washington St Salisbury Md 21801

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): arteriosclerotic cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION —
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? —
20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Richard J. Colfer M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 12/29/88
EXAMINER'S NAME (TYPE OR PRINT): RICHARD J. COLFER, MD ADDRESS: 2913 Traffic Circle Rd Darlington, MD 21034

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 1-3-1989
23c. NAME OF CEMETERY OR CREMATORY: Asbury UM Church Cem
23d. LOCATION CITY OR TOWN: Mt Vernon COUNTY: Somerset STATE: MD
24. FUNERAL DIRECTOR NAME: Bounds Funeral Home ADDRESS: Salisbury Md.
25a. DATE REC'D. BY REGISTRAR: JAN 04 1989
25b. REGISTRAR'S SIGNATURE: Gina Davidson-Richards

DHMH - 17 (VR A15 ME (5))

017063 DEC 22 88

FOR LOCAL REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36835

1. DECEASED NAME (TYPE OR PRINT): FIRST Sam MIDDLE Ella LAST Ladd

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ MONTH DAY YEAR 19

2b. HOUR M

3. SEX: F

4. RACE: BLACK

5. DATE OF BIRTH: MONTH 5 DAY 10 YEAR 10

6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 19 YEAR 1988

2d. HOUR 6P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Haynes Ark

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD

10. CITY OR TOWN OF DEATH: Joppatowne

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1174 Plaza Circle

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): —

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Harford

13c. CITY OR TOWN: Joppatown

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 1174 Plaza Circle 21085

14. FATHER'S NAME: FIRST Sam MIDDLE — LAST Jackson

15. MOTHER'S MAIDEN NAME: FIRST Sam Ella MIDDLE — LAST Leadbetter

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 431-82-5228

17. INFORMANT: Daughter - Juanita McKinney ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): —

DUE TO, OR AS A CONSEQUENCE OF (c): —

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Melanoma & bone metastases

19a. DATE OF OPERATION: —

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? —

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH: —

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Richard J. Colfer M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 12/19/88

EXAMINER'S NAME (TYPE OR PRINT): RICHARD J. COLFER MD ADDRESS: 2013 Tuffle Church Road Baltimore, Md. 21234

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal

23b. DATE: 12-19-88

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR: State Anatomy Board ADDRESS: Balto., Md.

25a. DATE REC'D BY REGISTRAR: DEC 21 1988

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

018287 JAN - 6 89 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO 3 6 8 3 6

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: THELMA | MIDDLE: Marguerite | LAST: LAVEN LAVEN | 2a. DATE OF DEATH MONTH DAY YEAR: 12-19-88 | 2b. HOUR: 4:53 P M | |
| 3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: May 8, 1902 | 6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS | # UNDER 1 YEAR MONTHS / DAYS | # UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Anderson Indiana | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD. | | |
| 10. CITY OR TOWN OF DEATH: Fallston 21047 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Homemaker | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Harford Co. | Bel Air 21014 | YES ☐ NO ☒ | 616 East Wheel Road 21014 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Wilbert O. Rhoton | Ida Mae Megan |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Daughter) 838-7366 ADDRESS |
|---|---|---|---|
| NO | — | 320-14-3798 | Mrs. Betty L. Engquist 616 East Wheel Road Bel Air, Maryland 21014 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a): Cardiac arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): H/o recent CVA, Dementia

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 12/19/88 to 12/19/88, that (I) (we) last saw the deceased alive on 12/19/88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Pat Weber MD | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑ | 12/19/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| PAT WEBER M.D. | FALLSTON GENERAL ER |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Entombment | Dec. 22, 1988 | Memorial Park Cemetery | Skokie, Cook Co., Illinois |

| 24. FUNERAL DIRECTOR: Joseph William Foster | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Joseph William Foster | 50 W. Broadway & Williams St Bel Air, Maryland 21014 | DEC 20 88 | Julia Davidson-Randall |

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

017793 DEC 30 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO. 36837

1. DECEASED NAME (TYPE OR PRINT): FIRST Everett; MIDDLE E.; LAST Linkous

2a. DATE OF DEATH: MONTH 12; DAY 23; YEAR 88

2b. HOUR: 6 27 AM

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: MONTH 09; DAY 08; YEAR 1906

6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS. IF UNDER 1 YEAR: MONTHS, DAYS. IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia

7b. CITIZEN OF WHAT COUNTRY? United States

8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: FALLSTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Farmer

12b. KIND OF BUSINESS OR INDUSTRY: Agriculture

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD; 13b. COUNTY: Harford; 13c. CITY OR TOWN: Pylesville; 13d. INSIDE CITY LIMITS? YES ☐ NO ☑; 13e. STREET ADDRESS: 5206 Rocks Rd. 21132

14. FATHER'S NAME: FIRST William; MIDDLE W.; LAST Linkous

15. MOTHER'S MAIDEN NAME: FIRST Sallie; MIDDLE; LAST Sparks

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 218-12-3288

17. INFORMANT ADDRESS: Lottie Linkous, 5206 Rocks Rd., Pylesville, MD

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiorespiratory collapse — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b): Ecchymosis

DUE TO, OR AS A CONSEQUENCE OF (c): Subdural Haematoma

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: 12/5/88

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Acute Subdural Haematoma

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2): No history of injury

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from ____ 19____ to 12/23 19 88, that (I) (we) last saw the deceased alive on 12/22 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J. Douglas Abbott M.D. DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12/27/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): J. Douglas Abbott M.D.

22e. ADDRESS: Suite 106 1714 Harford Rd Fallston Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 12/26/88

23c. NAME OF CEMETERY OR CREMATORY: Fawn Grove

23d. LOCATION: CITY OR TOWN Fawn Grove; COUNTY York; STATE PA

24. FUNERAL DIRECTOR NAME AND ADDRESS: Harkins Funeral Home 600 Main St, Delta Pa

25a. DATE REC'D BY REGISTRAR: DEC 28 1988

25b. REGISTRAR'S SIGNATURE

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP____

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 3 6 8 3 8

1. DECEASED NAME (TYPE OR PRINT): First Dorothy Middle Henrietta Last Lucot — DOROTHY H LUCOT
2a. DATE OF DEATH: Month Day Year — 12-9-88
2b. HOUR: 5 40 PM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: Month Day Year — June 5, 1922
6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS
If under 1 year: Months / Days
If under 24 hrs: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD
10. CITY OR TOWN OF DEATH: FALLSTON
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GENERAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker
12b. KIND OF BUSINESS OR INDUSTRY: --

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Harford
13c. CITY OR TOWN: Edgewood
13d. INSIDE CITY LIMITS? YES [ ] NO [ ]
13e. STREET ADDRESS: 2311 Shannon Road 21040

14. FATHER'S NAME: First Arthur Middle Lockwood Last Finkenbinder
15. MOTHER'S MAIDEN NAME: First Cora Middle Jean Last Sauer
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no
(IF YES, GIVE WAR OR DATES): none
16b. SOCIAL SECURITY NO.: 216-16-8952
17. INFORMANT: Andrew W.Lucot,Jr., ADDRESS: 2311 Shannon Rd. Edgewood Md. 21040

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b): Massive Intracerebral Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2):
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):
21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/6 19 88 to 12/9/88 19 88, that (I) (we) last saw the deceased alive on 12/9 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Walter Zawislak DEGREE: MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]
22c. DATE SIGNED: 12/9/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Zawislak
22e. ADDRESS: Fallston Gen. Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Dec. 13, 1988
23c. NAME OF CEMETERY OR CREMATORY: Trinity Lutheran Cemetery
23d. LOCATION: CITY OR TOWN / COUNTY / STATE: Joppa Harford Md.

24. FUNERAL DIRECTOR: NAME / ADDRESS: Howard K. McComas III, Abingdon, Md. 21009
25a. DATE RECD. BY REGISTRAR: DEC 12 88
25b. REGISTRAR'S SIGNATURE: Gicha Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

17765 DEC 30 88

BP 12

DHMH - 1650M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

88 REG NO 036839

018560 JAN - 3 89

1a. DECEASED NAME (TYPE OR PRINT) FIRST ANTHONY MIDDLE LAST MALINOWSKI

2a. DATE OF DEATH MONTH 12 DAY 29 YEAR 88

2b. HOUR 2:22 P M

3. SEX M

4. RACE W

5. DATE OF BIRTH MONTH FEB DAY 6 YEAR 1919

6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS

IF UNDER 1 YEAR MONTHS DAYS

IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.

10. CITY OR TOWN OF DEATH TALLSTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) TALLSTON GENERAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TAILOR

12b. KIND OF BUSINESS OR INDUSTRY SELF EMPL

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE MD

13b. COUNTY BALTO

13c. CITY OR TOWN KINGSVILLE

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE 11800 CHAPMAN RD 21087

14. FATHER'S NAME FIRST JACOB MIDDLE LAST MALINOWSKI

15. MOTHER'S MAIDEN NAME FIRST ANTOINETTE MIDDLE KUCINSKA LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES (IF YES, GIVE WAR OR DATES) WW II

16b. SOCIAL SECURITY NO. 213-05-2605

17. INFORMANT ANNA MALINOWSKA ADDRESS 11800 CHAPMAN RD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12/29/88

DUE TO, OR AS A CONSEQUENCE OF (b) Severe Cerebral anoxia — 12/26/88

DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac Arrest — 12/26/88

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/26 19 88, to 12/29 19 88, that (I) (we) last saw the deceased alive on ____ 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Walter Jaworski MD

DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED 12/29/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jaworski

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL

23b. DATE 1/3/89

23c. NAME OF CEMETERY OR CREMATORY ST STANISLAVS

23d. LOCATION CITY OR TOWN BALTO COUNTY MD STATE

24. FUNERAL DIRECTOR NAME JOHN M WEBER & SONS INC ADDRESS 401 S CHESTER ST

25a. DATE REC'D. BY REGISTRAR JAN 4 1989

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please mail page 1 to the local registrar. Page 3 should be retained by the funeral director for filing with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal from the state. If the certificate cannot be completed within 72 hours after death, a report should be mailed to the local registrar.

IMPORTANT: If item 21 is marked or item 18 shows any injury, an additional report must be made to the medical examiner.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP ____

DHMH - 16 60M 7/84 (VRA 15, 4)

017394 DEC 28 88 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

S 8 3 6 8 4 0
REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST: William | MIDDLE: Calvin | LAST: Martin | 2a. DATE OF DEATH: MONTH 12 DAY 07 YEAR 88 | 2b. HOUR 4:15 AM |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: MONTH Nov. DAY 14 YEAR 1908 | 6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD. | | |
| 10. CITY OR TOWN OF DEATH: Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Machinist | 12b. KIND OF BUSINESS OR INDUSTRY: Mfg. | | |

**USUAL RESIDENCE** (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Harford | Joppa | YES ☐ NO ☒ | 1823 Mountain Road 21085 |

| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | |
|---|---|---|---|---|---|
| FIRST: Howard | MIDDLE: (unknown) | LAST: Martin | FIRST: Mary | MIDDLE: A. | LAST: Krause |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | none | 216-09-9498 | Kathleen B. Martin | 1823 Mountain Road, Joppa Md. 21085 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrythmia
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Cerebro-Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Iron Deficiency Anemia; Urinary Bladder Obstruction - Prostate

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 11-25- 19 88, to 12 -7- 19 88, that (I) (we) last saw the deceased alive on 12-6- 19 88, and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Kermit P. Bonovich, MD. | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | 12-7-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Kermit P. Bonovich MD | 754 Hickory Ave Bel Air, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION: CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec. 9, 1988 | Mountain Christian Cemetery | Joppa Harford Md. |

| 24. FUNERAL DIRECTOR: NAME / ADDRESS | 25. DATE RECEIVED BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Howard K. McComas III, Abingdon, Md. 21009 | DEC 08 88 | Grace Davidson-Randall |

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR — REG. NO. 88 036341

1. DECEASED NAME (TYPE OR PRINT): First Mark; Middle C.; Last Mc Cluskey
2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ — Month 12 Day 8 Year 88
2b. HOUR: M
3. SEX: Male
4. RACE: Caucasian
5. DATE OF BIRTH: Month 2 Day 13 Year 64
6. AGE (IN YEARS LAST BIRTHDAY): 24 YRS.
IF UNDER 1 YR. MONTHS / DAYS
IF UNDER 24 HRS. HOURS / MIN.
2c. DATE PRONOUNCED DEAD: Month 12 Day 8 Year 88
2d. HOUR: 3:44P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland United
7b. CITIZEN OF WHAT COUNTRY? States of America
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD.
10. CITY OR TOWN OF DEATH: Havre de Grace
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Cook
12b. KIND OF BUSINESS OR INDUSTRY: U.S.Navy

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Harford
13c. CITY OR TOWN: Port Deposit
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS: 74 Main Street 21904

14. FATHER'S NAME: First Raymond; Middle V.; Last McCluskey
15. MOTHER'S MAIDEN NAME: First Theresa; Middle; Last Eichinger
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes
16b. SOCIAL SECURITY NO.: 219-90-8320
17. INFORMANT: Raymond McCluskey — ADDRESS: 3611 TRinity Dr. Bowie, Md.20715

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple injuries
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS: UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY: HOUR A.M. 2:00PM MONTH 12 DAY 8 YEAR 88
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Driver in auto/fixed object collision
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): road
21f. LOCATION: STREET Route 222; CITY OR TOWN Harford County; COUNTY; STATE Maryland

22a. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.
ACTUAL SIGNATURE: Charles P. Kokes
TITLE (SPECIFY): Acting Deputy Chief M.D. MEDICAL EXAMINER
DATE SIGNED: 12-10-88
VC
EXAMINER'S NAME (TYPE OR PRINT): Charles P. KOkes,M.D. ADDRESS: 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 12-12-88
23c. NAME OF CEMETERY OR CREMATORY: Maryland Veteran's
23d. LOCATION: CITY OR TOWN Cheltenham; COUNTY Prince GEorges; STATE Md.
24. FUNERAL DIRECTOR: NAME AND ADDRESS: Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, Maryland
25a. DATE REC'D BY REGISTRAR: DEC 13 1988
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landrum

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 5. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP
DHMH - 17 (VR A15 ME (5))

017295 DEC 27 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36842 REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal from the state.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other [illegible] the medical examiner must be notified of [illegible].

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: CHARLES | MIDDLE: LEO | LAST: MCDONNELL | 2a. DATE OF DEATH MONTH: 12 | DAY: 17 | YEAR: 88 |
| 2b. HOUR: 10:25 AM | | | | | |
| 3. SEX: M | 4. RACE: W | 5. DATE OF BIRTH MONTH: 6 DAY: 13 YEAR: 25 | 6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): South Africa | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD. | | |
| 10. CITY OR TOWN OF DEATH: Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GEN'L HOSP. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED ENG. | 12b. KIND OF BUSINESS OR INDUSTRY: U.S. postalSer. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md. | 13b. COUNTY: Harford | 13c. CITY OR TOWN: Edgewood | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 2509 Hanson Rd. 21040 | |
| 14. FATHER'S NAME FIRST: Lawrence | MIDDLE: Joseph | LAST: McDonnell | 15. MOTHER'S MAIDEN NAME FIRST: Edith | MIDDLE: Josephine | LAST: Born |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 578-22-4097 | 17. INFORMANT: Mrs. Dorothy McDonnell, | ADDRESS: 2509 Hanson Rd. Edgewood, Md. 21040 | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): acute MI

DUE TO, OR AS A CONSEQUENCE OF

(b): CAD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Walter Zawislak M.D. | DEGREE: MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ | 22c. DATE SIGNED: 12/17/88 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Zawislak | 22e. ADDRESS: Fallston Gen. Hospital Fallston, Md. | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation | 23b. DATE: 12-19-1988 | 23c. NAME OF CEMETERY OR CREMATORY: Westview Crematory | 23d. LOCATION CITY OR TOWN: Westview | COUNTY: Baltimore STATE: MD. |
| 24. FUNERAL DIRECTOR NAME: Lawsha, Kingsville, | ADDRESS: 11750 Belair Rd Md. 21087 | 25a. DATE REC'D BY REGISTRAR: DEC 21 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

015684 DEC 8 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 356843 REG. NO

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| LUCILE | EILA | McDOWELL | 12-6-88 | 8 15 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Female | White | Aug. 28, 1921 | 67 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Virginia | U.S.A. | | Harford County, MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Fallston | Fallston General Hospital | Homemaker | Home |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Harford | Joppa | YES ☐ NO ☒ | 1607 Clayton Rd. 21085 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Otho | | Gray | Sarah | Elizabeth | Johnson |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | ----- | 220-20-6565 | Elizabeth M. Corbett | Forest Hill, MD 21051 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Heart Failure | 1 year |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) | Kidney Failure | 1 week |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Pulmonary Hypertension | 10 years |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 12/1, 19 88, to 12/5, 19 88, that (I) (we) last saw the deceased alive on 12/6, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|---|
| David E. Grace | MD | | 12-6-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| David E. Grace | 112 So Bond Bel Air 21014 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | DEC. 9, '88 | BELAIR MEM. GARDENS | HARFORD CO., MARYLAND |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25. DATE RECD. BY REGISTRAR | 26. REGISTRAR'S SIGNATURE |
|---|---|---|
| WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD. | DEC 07 1988 | Julia Nielsen Kendall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

018654 JAN 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 036841 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pages 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | Lundy C Meadows | | | 2a. DATE OF DEATH MONTH DAY YEAR | Dec, 23 1988 |
| | | | | 2b. HOUR | 4:52 P M |
| 3. SEX | MALE | 4. RACE | WHITE | 5. DATE OF BIRTH MONTH DAY YEAR | 3-11-11 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 77 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS: HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY? | USA | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | XX |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Harford MD. | | | | |
| 10. CITY OR TOWN OF DEATH | Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Harford Memorial Hosp. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | FARMER |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MARYLAND | CECIL | RISING SUN | YES / NO X | 538 LITTLE NEW YORK 21911 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | |
|---|---|---|
| JAMES MEADOWS | LOUISE HORN | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 212-20-8751 | HARVEY MEADOWS | 491 TELEGRAPH ROAD RISING SUN, MARYLAND |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CHF | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | COPD Resp insuff | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | ASCVD | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES / NO |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN | 22c. DATE SIGNED |
|---|---|---|---|
| J T Lee | MD | X | 12-27-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| J T Lee | Union Med Clinic |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 12-27-88 | WEST NOTTINGHAM | COLORA CECIL MARYLAND |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| R.T. FOARD FUNERAL HOME RISING SUN, MD | DEC 27 '88 | Julia Davidson Rowlett |

BP 3

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 88 036845

0108839 DEC 20 88

1. DECEASED NAME (TYPE OR PRINT) First: Alice Middle: B Last: Mendenhall
2a. DATE OF DEATH Month Day Year: Dec. 1 1988
2b. HOUR: 10:00 P M
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH Month Day Year: Sept. 16 1899
6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS. If under 1 year: Months / Days. If under 24 hrs: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.
10. CITY OR TOWN OF DEATH: Havre de Grace
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hosp.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife
12b. KIND OF BUSINESS OR INDUSTRY: -----

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Harford
13c. CITY OR TOWN: Havre de Grace
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 505 Congress Ave., 307 St.John's Towers 21078

14. FATHER'S NAME First: Webster Middle: --- Last: Brown
15. MOTHER'S MAIDEN NAME First: Harriet Middle: --- Last: McMullen
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): -----
16b. SOCIAL SECURITY NO.: 214-74-3624
17. INFORMANT ADDRESS: Miriam B. Lindenmuth Perryville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Respiratory failure.
DUE TO, OR AS A CONSEQUENCE OF (b): metastatic ca c malignant effusion.
DUE TO, OR AS A CONSEQUENCE OF (c): undetermined primary cancer.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Hong Sun Kim M.D.
DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12-4-88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): HONG SUN KIM
22e. ADDRESS: Union Ave., Havre de Grace, Md 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Dec.6,1988
23c. NAME OF CEMETERY OR CREMATORY: Rosebank Cemetery
23d. LOCATION CITY OR TOWN / COUNTY / STATE: Rising Sun Cecil Maryland
24. FUNERAL DIRECTOR: Lee A. Patterson & Son ADDRESS: Lee A. Patterson & Son, Perryville, Maryland
25a. DATE REC'D. BY REGISTRAR: DEC - 5 '88
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Ford

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

R

BP 10

DHMH - 1650M 1/81 (VRA 15, 4)

017494 DEC 22 88

Item21b PerM.E. FilmG652 6/9/89 CG

FOR REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 7 6 3 4 5

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 99 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Alverta | MIDDLE: Rachel R. | LAST: Curtis Merryman | 2a. DATE KNOWN XX OF DEATH / ESTIMATED ☐ MONTH: 12 DAY: 19 YEAR: 88 | 2b. HOUR: M | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH: July DAY: 30 YEAR: 1912 | 6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS. IF UNDER 1 YR. MONTHS: DAYS: IF UNDER 24 HRS. HOURS: MIN: | 2c. DATE PRONOUNCED DEAD MONTH: 12 DAY: 19 YEAR: 88 | 2d. HOUR: 2:27P M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD | | |
| 10. CITY OR TOWN OF DEATH: Fallston | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Machine Operator | 12b. KIND OF BUSINESS OR INDUSTRY: Black & Decker | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Baltimore | 13c. CITY OR TOWN: Cockeysville | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 823 Warren Rd., 21030 | |
| 14. FATHER'S NAME FIRST: William | MIDDLE: Harrison | LAST: Curtis | 15. MOTHER'S MAIDEN NAME FIRST: Rosa | MIDDLE: Virginia | LAST: Hedrick |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): - | 16b. SOCIAL SECURITY NO.: 220-03-2958 | 17. INFORMANT ADDRESS: Walter C. Merryman, Jr., 827 Warren Rd. Cockeysville, Md. 21030 | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Multiple injuries

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES XX NO ☐ |
| 21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR: 1:15 P.M. 12-19-88 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Driver in auto/truck impact | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): road | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE: Route 146 and 23, Harford County, MD | |

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Margarita A. Korell TITLE (SPECIFY) M.D.: Assistant MEDICAL EXAMINER DATE SIGNED: 12-20-88

EXAMINER'S NAME (TYPE OR PRINT): Margarita A. Korell, M.D. ADDRESS: 111 Penn Street, Baltimore, Md 21201

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/22/88 | 23c. NAME OF CEMETERY OR CREMATORY: Poplar United Meth. Ch. | 23d. LOCATION CITY OR TOWN: Cem. Phoenix | COUNTY: Balto. STATE: Md. |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: Martin D. Lawson, 10 W. Padonia Rd. | | 25a. DATE REC'D. BY REGISTRAR: DEC 22 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

0193 18 JAN

FOR STATE REGISTRAR 388

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 38 3 6 8 4 7

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH | DAY | YEAR | 2b. HOUR |
|---|---|---|---|---|---|---|
| RUFUS | LEE | MILLER | 12 | 30 | 1988 | 3:40 P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Male | White | Feb. 25, 1904 | 84 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| North Carolina | USA | MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | HARFORD COUNTY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| HAVRE DE GRACE | CITIZENS NURSING HOME | Coal Miner | Coal |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Harford | Abingdon | YES ☐ NO ☒ | 2814 Emmorton Road 21009 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Unknown | | | Teller | -- | Miller |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | -- | 285-09-1566 | Jeanette M.Anders | Abingdon, Md. 21009 2814 Emmorton Road |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) ARRHYTHMIA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): DIABETES MELLITUS

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from ____, 19__, to 12/30, 19 88, that (I) (we) last saw the deceased alive on 12/30, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Dante N. Monakil | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/30/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DANTE N. MONAKIL | Havre de Grace, Md 21078 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Jan.3,1989 | C.M.Miller Cenetery | Jefferson Ashe N.C. |

| 24. FUNERAL DIRECTOR | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Howard K. McComas III, Abingdon, Md. 21009 | JAN 03 '89 | Julia Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 15

DHMH - 16 50M 1/81 (VRA 15, 4)

17274 DEC 27 88

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36848 REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be omitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 14 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST Gordon | MIDDLE Elliot | LAST Moore | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR 1274 M |
| | Gordon | E | Moore | December 9 1988 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| Male | White | Nov. 27, 1927 | 61 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Rhode Island | USA | | Harford MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Havre de Grace | Harford Memorial Hosp. | | Fireman | US govt-Ret. | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
|---|---|---|---|---|---|
| Maryland | Harford | Edgewood | YES ☐ NO X | 318 Crestwood Drive | 21040 |

| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | |
|---|---|---|---|---|---|
| FIRST Davis | MIDDLE Smith | LAST Moore | FIRST Kirstin | MIDDLE Mary | LAST Jacobsen |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WWII | 039-14-7442 | Yvonne S. Moore, 318 Crestwood Drive | Edgewood, Md. 21040 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO X | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 12-9 1988 to 12-9 1988, that (I) (we) last saw the deceased alive on 12-9 1988 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE ATTENDING PHYSICIAN X MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED 12/9/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT) LINDA [illegible] 22e. ADDRESS 1604 Churchville Road

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec. 12, 1988 | Harford Memorial Gardens, Aldino | Harford Md. |

24. FUNERAL DIRECTOR: Howard K. McComas III, Abingdon, Md. 21009

25a. DATE RECEIVED BY REGISTRAR: DEC 09 88

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH - 16 50M 1/81 (VRA 15, 4)

018292 JAN 6-88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 036849

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Della MIDDLE: Mae LAST: Moulsdale | | | 2a. DATE OF DEATH MONTH DAY YEAR: 12 20 88 | 2b. HOUR: 9:55 A.M. |
| DELLA MAE MOULSDALE | | | | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Aug. 16, 1913 | 6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Nebraska | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD. | |
| 10. CITY OR TOWN OF DEATH: HAVRE DE GRACE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HARFORD MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Baker | 12b. KIND OF BUSINESS OR INDUSTRY: Bd. of Education |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Harford | Abingdon | YES ☐ NO ☒ | 804 Philadelphia Avenue 21009 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | |
|---|---|---|
| William M. Blevins | Alta Leona Craig | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES): none | 16b. SOCIAL SECURITY NO.: 213-01-9918 | 17. INFORMANT: Norman K.Moulsdale, 3728 Washington Ave., ADDRESS: Abingdon, Md. 21009 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcenoma of Duodenum — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b): with Multiorgan Metastasis — Approx one year.
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Permanent Pacemaker for Complete heart blok A SCH

| 19. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☑ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| ☐ | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from Dec. 4, 1988 to 12/20 19 88, that (I) (we) last saw the deceased alive on 12/20 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
|---|---|---|---|
| Edward C. Loo M.D. | ATTENDING PHYSICIAN ☒ | MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/20/88 |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT): Edward C. Loo, M.D. | 22d. ADDRESS: Havre de Grace, Md. 21078 | | |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec. 23, 1988 | Cokesbury U.M. Cemetery | Abingdon Harford Md. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Howard K. McComas III, Abingdon, Md. 21009 | DEC 21 '88 | Julia Davidson-Randall |

018879 JAN 17 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 036850

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Joseph MIDDLE: Martin LAST: Oberle | | | | | | | | 2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ MONTH DAY YEAR 19 | 2b. HOUR M |
| JOSEPH M OBERLE | | | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN | | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR | 2d. HOUR |
| Male | White | 8 26 15 | 73 YRS. | | | | | 12-29 1988 | 9:02 AM |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Indiana | USA | | | | | | | Harford MD | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| BEL AIR | 1407-R Churchville Road | | | | | | | USARMY - RET | US-Govt. |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS | | | | | |
| Md | Harford | BEL AIR | | 1407 Churchville Rd 21014 | | | | | |
| 14. FATHER'S NAME FIRST: John MIDDLE: ~~Wesley~~ LAST: Oberle | | | | 15. MOTHER'S MAIDEN NAME FIRST: Alice MIDDLE: Georgia LAST: Sterling | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS | | | | | |
| Yes | WW II | 493-07-5431 | ~~[redacted]~~ LeAlyce Garrett | 1407 Churchville Rd BelAir, Md. 21014 | | | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Atherosclerotic cardiovascular disease | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
|---|---|---|
| | | |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Richard J. Colfer M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 12/29/88

EXAMINER'S NAME (TYPE OR PRINT) RICHARD J. COLFER MD ADDRESS 2613 Taylor Church Rd Darlington, Md. 21034

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Cremation | Dec. 30, 1988 | R.A. Ferris Crematory | W. Chester | Chester | Pa. |

| 24. FUNERAL DIRECTOR (NAME) | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Howard K. McComas III, Abingdon, Md. 21009 | DEC 29 '88 | Julia Davidson-Randall |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 4 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP 10+1

DHMH - 17
(VR A15 ME (5))

018028 JAN -4 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR Items #18-22A Per M. E. Film #G649 3/7/89 JM

REG. NO. 3 6 8 5 1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ | MONTH | DAY | YEAR / 2b. HOUR |
| | Kenneth | Thomas | Peters | | 12 | 25 | 88 / M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. | 2c. DATE PRONOUNCED DEAD | 2d. HOUR |
| Male | White | July 12 1963 | 25 YRS. | | | 12-25-88 | 11:03a |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| New York | USA | | Harford County MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Fallston | Fallston General Hospital | Laborer | Landscaping | | | | |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Harford | Abington | YES ☐ NO ☒ | 2812 Merrideth Court, 21009 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Thomas | Joseph | Peters | Ann | Marie | Searah |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | - | 219-90-2985 | Mr. Thomas J. Peters, 79 Spring Time Way, Balto., Md. 21234 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY: Acute Narcotic Intoxication — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) _____

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) _____

DUE TO, OR AS A CONSEQUENCE OF (c) _____

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21a. EXTERNAL CAUSE WAS | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 12/25 19 88 | UNKNOWN |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | HOME | 2812 Meredith court | Abingdon | Harford | MD. |

22a. I certify that I took charge of the remains described above, held a Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE _____ M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 12-26-88

EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. ADDRESS 111 Penn Street

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | 12/30/88 | Belair Memorial Gardens | Belair | Harford | Md. |

| 24. FUNERAL DIRECTOR NAME | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Martin D. Lawson, 10 W. Padonia RD. | DEC 30 1988 | |

07/84 25M BR 226 DHMH - 17 (VR A15 ME (5))

B15931 DEC 18-88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36852
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Registrar of Vital Statistics and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If medical certification is marked at Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH | DAY | YEAR | 2b. HOUR |
| Albert | Frank | Piasecki | December | 10, | 1988 | 1:30 A.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH | DAY | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|---|---|
| Male | White | 10 | 02 | 28 | 60 YRS | | | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | | Harford County MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Fallston | Fallston General Hospital | Electrical Tech. | City of Balto. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Md. | Harford | Bel Air | YES X NO ☐ | 406 Harrington Rd. 21014 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Michael | Joseph | Piasecki | Anna | | Skoczynski |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | Korea | 218-22-8699 | Theresa A. Piasecki | 406 Harrington Rd. 21014 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular Arrhythmia

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Strong smoking History (COPD) Diabetes

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 12/5, 19 88, to 12/10, 19 88, that (I) (we) last saw the deceased alive on 11/15, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| [signature] | MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/10/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DAVID McClure MD | 1131 Bel Air Road Bel Air Md 21014 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | 12-14-88 | Sacred Heart of Jesus | Dundalk, | Balto. Co., | Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Charles S. Zeiler & Son Inc. | 6224 Eastern Ave. | DEC 12 1988 | Julia Sanderson-Randall |

20 BP

DHMH - 16 60M 7/84
(VRA 15, 4)

018290 JAN 6 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 036853

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR | |
| Robert | D | Potts | Dec 26 88 | 6:20 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| MALE | WHITE | NOVEMBER 25, 1898 | 90 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| PA | USA | | Harford County MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Havre de Grace | Harford Memorial Hospital | | (RET) MECH. ENG. TECH. | FED GOVT (APG) | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | HARFORD | HAVRE de GRACE | YES ☒ NO ☐ | 658 FRANKLIN STREET 21078 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| CHARLES | O. | POTTS | FRANCES | A. | DARBY |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 205 05 4999 | SPEPHEN P. KINSEY | 843 OTSEGO ST., HdG, MD 21078 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebro-vascular Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 dy

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Cerebro-vascular disease

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic Cardiac Failure Pneumonia

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 12-12, 1988, to 12-26, 1988, that (I) (we) last saw the deceased alive on ____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Irvin L. Wachsman | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/26/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| IRVIN WACHSMAN, M.D. | NORTH UNION AVENUE, HAVRE de GRACE, MD 21078 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 28DECEMBER1988 | ANGEL HILL CEMETERY | HAVRE de GRACE, HARFORD CO., MD |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| MITCHELL-SMITH FUNERAL HOME PA, HAVRE de GRACE, MD 21078 | DEC 27 '88 | Julia Davidson-Randall |

R BP 8

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 88 036854

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Claude | MIDDLE: R | LAST: Reeves | 2a. DATE OF DEATH MONTH DAY YEAR: Dec 10 88 |
| 2b. HOUR: 12 30 AM | | | |
| 3. SEX: male | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR: 4-01-08 | 6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): N. CAROLINA | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford Cty MD |
| 10. CITY OR TOWN OF DEATH: Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): TRUCK DRIVER | 12b. KIND OF BUSINESS OR INDUSTRY: |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MARYLAND | HARFORD | DARLINGTON | YES ☐ NO XX | 4432 CONOWINGO ROAD 21034 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| EVERETT REEVES | MARGARET WHITAKER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | 17. INFORMANT ADDRESS |
|---|---|---|
| NO | N/A | 215-18-6734 — WILDA A. SAPP 749 CONOWINGO ROAD CONOWINGO, MD 21918 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF (c): ARTERIOSCLEROSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): HRema

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 11/26, 19 88, to 12/9, 19 88, that (I) (we) last saw the deceased alive on 12/9, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Donte M. Monakil Dmn | ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/10/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DONTE M. MONAKIL | Havre de Grace Md 21078 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 12-13-88 | DARLINGTON CEMETERY | DARLINGTON HARFORD MD |

| 24. FUNERAL DIRECTOR NAME, ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| R.T. FOARD FUNERAL HOME, RISING SUN, MD | DEC 12 '88 | Julia Davidson Randall |

BP 3

DHMH - 1650M 1/81
(VRA 15, 4)

018877 JAN 11 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO. 36855

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: JOHN | MIDDLE: E | LAST: RENN | 2a. DATE OF DEATH MONTH DAY YEAR: 12-22-88 | 2b. HOUR: 11:30 PM |
| 3. SEX: M | 4. RACE: W | 5. DATE OF BIRTH MONTH DAY YEAR: 04 08 00 | 6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS. | IF UNDER 1 YEAR MONTHS: 8 DAYS: 14; IF UNDER 24 HRS HOURS: MIN: |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD. | |
| 10. CITY OR TOWN OF DEATH: Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Citizens Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret. Nursing Asst. | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Harford | 13c. CITY OR TOWN: Havre deGrace | 13d. INSIDE CITY LIMITS? YES XX NO ☐ | 13e. STREET ADDRESS: 1241 Ontario St. 21078 |
| 14. FATHER'S NAME FIRST: George | MIDDLE: W. | LAST: Renn | 15. MOTHER'S MAIDEN NAME FIRST: Louise | MIDDLE: | LAST: Feighenne |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): N/A | 16b. SOCIAL SECURITY NO.: 215-24-6020 | 17. INFORMANT: Mrs. Louise Quirk | ADDRESS: 1307 Ontario St. Havre de Grace, Md. 21078 | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Obstructive Lung Disease

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12/23/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): LETICIA S. GALVEZ, M.D. | 22e. ADDRESS: 625 S. Union Ave. Havre De Grace, Md. 21078

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/27/88 | 23c. NAME OF CEMETERY OR CREMATORY: St. Paul's Lutheran | 23d. LOCATION CITY OR TOWN: Aberdeen, | COUNTY: Harford | STATE: Md. |
| 24. FUNERAL DIRECTOR NAME: Robert L. Tarring | ADDRESS: Tarring Funeral Home, P.A. 335 S. Parke St. Aberdeen, Md. | 25a. DATE REC'D. BY REGISTRAR: DEC 28 '88 | 25b. REGISTRAR'S SIGNATURE: Lucia Davidson-Randall | |

0 1 7 0 0 0 DEC 22 88 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

88 REG. NO. 36856

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | VIRGIE / Bell / RICHARDSON | 2a DATE OF DEATH MONTH / DAY / YEAR | 12 / 9 / 88 | 2b HOUR | 12:15 P M |
| 3 SEX | F | 4 RACE | W | 5 DATE OF BIRTH MONTH / DAY / YEAR | 7 / 1 / 08 |
| 6 AGE (IN YEARS LAST BIRTHDAY) | 80 YRS | IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS. HOURS / MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Virginia | 7b CITIZEN OF WHAT COUNTRY? | U.S.A. | 8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 9 BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD. |
| 10 CITY OR TOWN OF DEATH | HAVRE DE GRACE | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | HARFORD MEMORIAL HOSPITAL | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | homemaker |
| | | | | 12b KIND OF BUSINESS OR INDUSTRY | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a STATE | 13b COUNTY | 13c CITY OR TOWN | 13d INSIDE CITY LIMITS? | 13e STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Harford | Aberdeen | YES XX NO ☐ | 179 Engle Ave. 21001 |

| 14 FATHER'S NAME FIRST / MIDDLE / LAST | 15 MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Claybe / McCarter | Celia / Hagy |

| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b SOCIAL SECURITY NO. | 17 INFORMANT ADDRESS |
|---|---|---|---|
| No | N/A | 215-32-9846 | Mr. Randolph Foster S.A.A. |

**MEDICAL CERTIFICATION**

18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CVA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) CHF

DUE TO, OR AS A CONSEQUENCE OF (c) GI bleeding

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

| 19a DATE OF OPERATION | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY? YES ☐ NO ☑ | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b SIGNATURE | DEGREE | 22c DATE SIGNED |
|---|---|---|
| Brian T. [illegible] | ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/9/88 |

| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | 22e ADDRESS |
|---|---|
| | |

| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b DATE | 23c NAME OF CEMETERY OR CREMATORY | 23d LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12/13/88 | Bel Air Mem. Gardens | Bel Air / Harford / Md. |

| 24 FUNERAL DIRECTOR NAME / ADDRESS | 25a DATE RECD. BY REGISTRAR | 25b REGISTRAR'S SIGNATURE |
|---|---|---|
| Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399 | DEC 12 88 | Jane Davidson-Randall |

018333 JAN -6 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO. 036857

1. DECEASED NAME (TYPE OR PRINT): First Glen; Middle D.; Last Rowland

2a. DATE OF DEATH: Month Dec; Day 20; Year 1988

2b. HOUR: 5:35 PM

3. SEX: Male

4. RACE: white

5. DATE OF BIRTH: Month April; Day 29; Year 1916

6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Shift Superintendent

12b. KIND OF BUSINESS OR INDUSTRY: Philadelphia Electric Co.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: PA.

13b. COUNTY: Lancaster

13c. CITY OR TOWN: Peach Bottom

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 177 Quarry Rd. 17363

14. FATHER'S NAME: First Amos; Middle W.; Last Rowland

15. MOTHER'S MAIDEN NAME: First Clemmie; Middle ---; Last Hartsoe

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): -----

16b. SOCIAL SECURITY NO.: 717-12-2561

17. INFORMANT: Theresa M. Sheets

ADDRESS: Peach Bottom, Penn.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Pul. Congestion & Edema d/t Cardiac

DUE TO, OR AS A CONSEQUENCE OF (b): fallure Poss Acute massive M.I.

DUE TO, OR AS A CONSEQUENCE OF (c): Ca of Upper lobe, Advanced COPD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Acute D.T. from alcoholism

19a. DATE OF OPERATION: 12/15/88

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ca of Lt upper lobe

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/14, 19 88, to 12/20, 19 88, that (I) (we) last saw the deceased alive on 12/20, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12/20/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): HENRY H. KWAH

22e. ADDRESS: 437 GIRARD ST. HAVRE DE GRACE MD 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Dec. 23, 1988

23c. NAME OF CEMETERY OR CREMATORY: Calvary Baptist Church Cem.

23d. LOCATION: CITY OR TOWN: Rising Sun; COUNTY: Cecil; STATE: Maryland

24. FUNERAL DIRECTOR (NAME): Lee A. Patterson & Son

ADDRESS: Perryville, Maryland

25a. DATE REC'D. BY REGISTRAR: DEC 23 '88

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the [illegible] and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remit pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal of the remains.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other [illegible] medical examiner must be notified at once.

BP 8

DHMH - 6 50M 1/81 (VRA 15/4)

AGNES M. SADLER

0 1 6 4 2 1 DEC 15 88 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 3 6 8 5 3 REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: AGNES | MIDDLE: M | LAST: Sadler | 2a. DATE OF DEATH MONTH: December | DAY: 12 | YEAR: 88 |
| 2b. HOUR: 1 40 A M | | | | | |
| 3. SEX: Female | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH: 9 | DAY: 23 | YEAR: 01 | 6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD. | | |
| 10. CITY OR TOWN OF DEATH: Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MARYLAND | HARFORD | JOPPA | YES ☐ NO ☒ | 301 Avedon Court 21085 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| | | HORAK | MARY | | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 220-24-6902 | John Sadler | 2015 Cypress Dr. Bel Air MD. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Depression & anorexia

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 12/1 19 88 to 12/12 19 88 that (we) last saw the deceased alive on 12/12 19 88 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~was~~) (~~did~~) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Andrew G. Feinberg | MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | 12/12/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Andrew G. Feinberg MD | 200 Melton Ave Fallston MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12-14-88 | Holy Redeemer Cem. | Baltimore Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Philip E. Cook | 1211 Cosaco Ave. | DEC 13 1988 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1650M 1/81 (VRA 15, 4)

016780 DEC 20 88 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH 88 REG. NO 036859

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Claire | Middle: M. | Last: Sanders | 2a. DATE OF DEATH Month/Day/Year: 12/12/88 | 2b. HOUR: 6 PM | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH Month/Day/Year: 03/11/14 | 6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS. | If under 1 year: Months / Days | If under 24 hrs: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD. | | |
| 10. CITY OR TOWN OF DEATH: Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Bookkeeper | 12b. KIND OF BUSINESS OR INDUSTRY: Accounting | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | Harford | Bel Air | YES [ ] NO [X] | 118 Glenwood Rd 21014 |

| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|---|---|
| First: Harry Middle: Last: Deppisch | First: Mary Middle: Last: Trageser | No | - | 212-18-2569 | Norman L. Sanders, 118 Glenwood Rd., Belair, Md. 21014 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Cardiac arrhythmia
DUE TO, OR AS A CONSEQUENCE OF (c): Hypertension + arteriosclerotic C-V disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [ ] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from June 19 87 to Dec. 19 88, that (I) (we) last saw the deceased alive on June 19 88 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Ben Oteyza | MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | Dec. 13/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| BEN OTEYZA | 846 S. MAIN ST., Bel Air Md 21014 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY |
|---|---|---|---|
| Burial | 12/15/88 | Dulaney Valley Mem. Gardens | Timonium Balto. Md. |

| 24. FUNERAL DIRECTOR (NAME) / ADDRESS | DATE RECEIVED BY REGISTRAR | REGISTRAR'S SIGNATURE |
|---|---|---|
| Bryan W. Clary, 10 W. Padonia Rd. | DEC 19 1988 | |

BP

DHMH - 1650M 1/81 (VRA 15, 4)

015979 DEC 13 88 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO. 36860

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH | DAY | YEAR | 2b. HOUR | |
|---|---|---|---|---|---|---|---|
| BEATRICE | C. | SCARBOROUGH | 12 | 7 | 88 | 3:25 | P. M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| F | W | July 18 1903 | 85 YRS | | | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Maryland | United States | MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | HARFORD MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| HAVRE DE GRACE | HARFORD MEMORIAL HOSPITAL | Merchant | General Store |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Harford | Darlington | YES ☒ NO ☐ | Main Street/21034 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| H. | Clinton | Scarborough | Grace | | Kelly |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | ---------- | 215-32-1223 | Lloyd H. Scarborough P.O. Box 26 Darlington, MD |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Metastasis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Metastatic Carcinoma — Primary Not Known

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☑ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 12/1, 19 88, to 12/7, 19 88, that (I) (we) last saw the deceased alive on 12/7, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Dante M. Monachino | ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/7/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DANTE MONACHINO | Havre de Grace, Md. 21078 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | 12/10/88 | Darlington Cemetery | Darlington | Harford | MD |

| 24. FUNERAL DIRECTOR (NAME) | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Harkins Funeral Home, Inc. | 600 Main St. Delta, PA | DEC 12 1988 | Julia Davidson-Landrum |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

016442 DEC 15 88 FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36861 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| MELVIN | BRADLEY | SCARBOROUGH | DECEMBER 12, 1988 | ? M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | NOVEMBER 4, 1906 | 82 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | | HARFORD COUNTY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| HAVRE de GRACE | 101 DARLINGTON ROAD | (RET) MAINT. SUPER. | ST. ROADS OF MD |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | HARFORD | HAVRE de GRACE | YES ☐ NO ☒ | 101 DARLINGTON ROAD 21078 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| HAMILTON | Y. | SCARBOROUGH | LIZZIE | CATHERINE | FEW |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| YES | | 213 38 7763 | MERRIL SCARBOROUGH, 4328 CONOWINGO RD, DARLINGTON, MD |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Generalized ArCVD and | 10YRS |
| DUE TO, OR AS A CONSEQUENCE OF (b) | HYPERTensive ArCVD and | 10YRS |
| DUE TO, OR AS A CONSEQUENCE OF (c) | old age | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: NO

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from MAY 5, 1970, to DECEMBER 12, 1988, that (I) (we) last saw the deceased alive on DEC 12 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE DEGREE | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|
| Dudley Phillips MD | | 13DECEMBER88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DUDLEY PHILLIPS, M.D. | MASONIC BUILDING, DARLINGTON, MD. 21034 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 15DECEMBER88 | ROCK RUN CEMETERY | ROCK RUN, HARFORD CO., MD. |

| 24. FUNERAL DIRECTOR NAME ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| MITCHELL-SMITH FUNERAL HOME PA, HAVRE de GRACE, MD 21078 | DEC 14 1988 | |

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

017149 DEC 27 88 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 3 6 8 6 2 REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: ROBERT | MIDDLE: SCHNEPFE | LAST: SHAULL | 2a. DATE OF DEATH MONTH: 12 DAY: 20 YEAR: 88 |
| 2b. HOUR: 3 34 PM | 3. SEX: Male | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: Oct. 21, 1913 |
| 6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD County MD. |
| 10. CITY OR TOWN OF DEATH: FALLSTON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GEN. HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Chemist | 12b. KIND OF BUSINESS OR INDUSTRY: Health Dept. |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Harford | 13c. CITY OR TOWN: Monkton | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ |
| 13e. STREET ADDRESS: 3050 Houcks Mill Road 21111 | | | |
| 14. FATHER'S NAME FIRST: Ira MIDDLE: | LAST: Shaull | 15. MOTHER'S MAIDEN NAME FIRST: Charlotte MIDDLE: | LAST: Schnepfe |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WW II | 16b. SOCIAL SECURITY NO.: 216-03-7976 | 17. INFORMANT: Clara-Jane Shaull | ADDRESS: same as above |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☒ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT): V. S. NAIR — 22e. ADDRESS: 2112 Belair Road

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/23/88 | 23c. NAME OF CEMETERY OR CREMATORY: Highview Mem. Gar. | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Fallston, Harford, Md. |
| 24. FUNERAL DIRECTOR NAME: M. Gladden Kurtz | ADDRESS: Jarrettsville, Md. | 25a. DATE RECD. BY REGISTRAR: DEC 23 1988 | 25b. REGISTRAR'S SIGNATURE: [signature] DEC 23 1988 |

017766 DEC 3088

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO. 36863

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Georgia (Glorgia) Middle: Mayfiel (M.) Last: Standiford (Standiford) | | | | 2a. DATE OF DEATH Month Day Year: 12-9-1988 | 2b. HOUR: 6:35 PM |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH Month Day Year: April 12, 1897 | 6. AGE (IN YEARS LAST BIRTHDAY): 91 YRS. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford | | MD. |
| 10. CITY OR TOWN OF DEATH: Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Upper Chesapeake Medical Center | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: --- | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Md. | Harford | Edgewood | YES ☐ NO ☒ | 2305 Philadelphia Rd. 21040 |

| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME |
|---|---|
| First: William Middle: Henry Last: Cage | First: Ada Middle: Belle Last: Wilson |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | 219-44-7205 --- | Dorothy M. Standiford | Edgewood, Md. 21040 2305 Philadelphia Rd. |

## 18. MEDICAL CERTIFICATION

**CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Artery Disease

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 12-8, 19 88, to 12-9, 19 88, that (I) (we) last saw the deceased alive on 12-9, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Dantre N. Monaicil | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/10/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DANTE N. MONACILL | Havre de Grace, Md 21078 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec. 14, 1988 | Cokesbury U.M. Cemetery | Abingdon Harford Md. |

| 24. FUNERAL DIRECTOR NAME, ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Howard K. McComas III, Abingdon, Md. 21009 | DEC 29 1988 | Julia Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 10

DHMH - 1650M 1/81 (VRA 15, 4)

015973 DEC 13-88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO 036864

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Elsie | MIDDLE: Amoss | LAST: Streett | 2a. DATE OF DEATH MONTH: 12 | DAY: 6 | YEAR: 88 | 2b. HOUR: 640 A/M |
| 3. SEX: F | 4. RACE: Cauc | 5. DATE OF BIRTH MONTH: Dec. DAY: 18 YEAR: 1904 | 6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD. | | | |
| 10. CITY OR TOWN OF DEATH: Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hosp. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Home | | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Md. | Harford | Fallston | YES [ ] NO [X] | 403 Whitaker Mill Rd. 21047 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Charles | Howard | Amoss | Margaret | Frances | Brooks |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | 213-38-5697 | J. Heuisler Streett, Fallston, Md. 21047 | 403 Whitaker Mill Rd. |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Acute myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF (c): ASHD

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Fractured of right hip.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 11/23/88 | Fractured R Hip | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a.1 **I certify** that (I) (this hospital) attended the deceased from 11/25, 19 88, to 12/6, 19 88, that (I) (we) last saw the deceased alive on 12/5, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Willard R Amoss | ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 12/6/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Willard R Amoss | 2303 Belair Rd Fallston, Md 21047 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12-9-1988 | Dulaney Valley Mem.G. | Timonium Balto. Md. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| E.F.Lassahn, 11750 Belair Rd. Kingsville, Md. 21087 | DEC 12 1988 | Julie Heuisler Lankford |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, medical [illegible] must be notified at once.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic [illegible]

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

016759 DEC 20 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO 036865

1. DECEASED NAME (TYPE OR PRINT): First Orazio Middle A. Last Sudano Jr.

2a. DATE OF DEATH: Month 12 Day 12 Year 88

2b. HOUR: 1:04 PM

3. SEX: M

4. RACE: WH

5. DATE OF BIRTH: Month 06 Day 10 Year 36

6. AGE (IN YEARS LAST BIRTHDAY): 52 YRS. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD.

10. CITY OR TOWN OF DEATH: Fallston

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Salesman

12b. KIND OF BUSINESS OR INDUSTRY: Automobile

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Baltimore

13c. CITY OR TOWN: Kingsville

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: 12695 Lee Ben Rd. 21087

14. FATHER'S NAME: First Orazio Middle A. Last Sudano Sr.

15. MOTHER'S MAIDEN NAME: First Sarah Middle Last Vince

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): yes (IF YES, GIVE WAR OR DATES): 1955-1957

16b. SOCIAL SECURITY NO.: 219-30-9693

17. INFORMANT: Carolyn A. Sudano, Kingsville, Md. 21087 ADDRESS: 12695 Lee Ben Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Ischemic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: Hour A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: Street / City or Town / County / State

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Joseph Reinhardt DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. Joseph Reinhardt M.D.

22e. ADDRESS: Fallston General Hos. Fallston, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 12-16-1988

23c. NAME OF CEMETERY OR CREMATORY: Most Holy Redeemer

23d. LOCATION: City or Town: Balto. City County: Md. State:

24. FUNERAL DIRECTOR (NAME): Leasburg Funeral Home ADDRESS: 11750 Belair Rd Kingsville Md 21087

25a. DATE RECD BY REGISTRAR: DEC 19 1988

25b. REGISTRAR'S SIGNATURE: Linda Dickson-Kemp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper sheets 1 and 2 and mail or take with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be advised.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

016586 DEC 19 88

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36866 REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| STANLEY | J. | SUESS | DECEMBER 13 1988 | 6:15 A.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | DEC. 18 1915 | 72 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| MD. | U.S.A. | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | HARFORD COUNTY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| BEL AIR | 615 GAIRLOCK PLACE | SELF-EMPLOYED | AWNINGS |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD. | HARFORD | BEL AIR | YES [ ] NO [X] | 615 GAIRLOCK PLACE 21014 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| JOHN | | SUESS | AMELIA | | UNKNOWN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| NO | | 213-03-0429 | GRETTA J. SUESS (WIFE) SAME ADDRESS |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of the Lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [ ] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 4/8, 19 88, to 12/13, 19 88, that (I) (we) last saw the deceased alive on 4/8, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| M. Zimring MD | ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] | 12/13/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DR. MICHAEL ZIMRING | 333 St. Paul Place |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 12/15/88 | BEL AIR MEMORIAL | BALTIMORE MD. |

| 24. FUNERAL DIRECTOR (NAME) ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| SCHIMUNEK FUNERAL HOME INC. 9705 Belair Rd., Baltimore, Md. 21236 | DEC 16 1988 | Julia Davidson-Rinaldi |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

017819 DEC 30

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO 036867

| | | | |
|---|---|---|---|
| 1a. DECEASED NAME (TYPE OR PRINT) FIRST: Ruth | MIDDLE: Ada | LAST: Suitt | 2a. DATE OF DEATH MONTH DAY YEAR: December 12, 1988 |
| 2b. HOUR: 8:30 P.M. | | | |

| | | | | | |
|---|---|---|---|---|---|
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: October 30, 1911 | 6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |

| | | | |
|---|---|---|---|
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD. |

| | | | |
|---|---|---|---|
| 10. CITY OR TOWN OF DEATH: Bel Air | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 410 South Fountain Green Road | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerk | 12b. KIND OF BUSINESS OR INDUSTRY: Retail |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE: Maryland | 13b. COUNTY: Harford Co. | 13c. CITY OR TOWN: Bel Air | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET ADDRESS / ZIP CODE: 410 South Fountain Green Road 21014 |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME FIRST: Noah | MIDDLE | LAST: Osborne | 15. MOTHER'S MAIDEN NAME FIRST: Jennie MIDDLE | LAST: Anders |

| | | | |
|---|---|---|---|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES): — | 16b. SOCIAL SECURITY NO.: 212-32-4171 | 17. INFORMANT (Daughter) 893-0228 ADDRESS: Mrs. Ruth Ann Ball | 3102 West Court Bel Air, Maryland 21014 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
(b): Alzheimer's
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____ 19 87, to Dec 13, 19 88, that (I) (we) last saw the deceased alive on _____ 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: David S. Dunn | DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED: Dec. 13, 1988 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): David S. Dunn, M.D. | 22e. ADDRESS: 1131 Bel Air Road, Bel Air, Maryland 21014 | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Dec. 15, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: Jarrettsville Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Jarrettsville, Harford Co., Md. |

| | | | |
|---|---|---|---|
| 24. FUNERAL DIRECTOR: Joseph William Foster Joseph William Foster | ADDRESS: 50 W. Broadway & Williams Sts. Bel Air, Maryland 21014 | 25a. DATE REC'D. BY REGISTRAR: DEC 13 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randello |

017470

FOR STATE REGISTRAR DEC 28 88

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36868 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If items 21, 22, 23, 24, 25a, and 25b are not marked or there is any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Mildred | Middle: D. | Last: Taylor | 2a. DATE OF DEATH Month/Day/Year: 12-12-1988 |
| 2b. HOUR: 8:20 P M | | | |
| 3. SEX: Female | 4. RACE: Black | 5. DATE OF BIRTH Month/Day/Year: 11/3/14 | 6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS |
| IF UNDER 1 YEAR: MONTHS / DAYS | # UNDER 24 HRS: HOURS / MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD. |
| 10. CITY OR TOWN OF DEATH: Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hosp | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Home maker | 12b. KIND OF BUSINESS OR INDUSTRY |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Md. | Harford | Aberdeen | YES ☒ NO ☐ | 42 Raymond Ave. 21001 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last | |
|---|---|---|
| William / Duncan | Irene / Scott | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 220-18-6268 |
| 17. INFORMANT ADDRESS: Earl Taylor - same as above (Son) | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIAC ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 MINUTES

DUE TO, OR AS A CONSEQUENCE OF (b): CONGESTIVE HEART FAILURE — 4 DAYS

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CHRONIC RENAL FAILURE

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) this hospital) attended the deceased from 12/12 19 88 to 19 , that (I) (we) last saw the deceased alive on 12/12 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| C Eck | MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/12/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): CHARLES R. ECK JR | 22e. ADDRESS: 219 W. BELAIR AVE, ABERDEEN | |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12-17-88 | Harford Mem Gard | Aldino / Harford / MD |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: Arnold Beard P.O. Box 188 H.O.G. MD | 25a. DATE REC'D. BY REGISTRAR: DEC 21 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

015789 DEC 1200

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR — REG. NO. 3 6 8 6 9

1. DECEASED NAME (TYPE OR PRINT): FIRST LAWRENCE MIDDLE LEE LAST TURNER

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ MONTH 12 DAY 5 YEAR 1988 — 2b. HOUR 5:22 P.M.

3. SEX: M — 4. RACE: B — 5. DATE OF BIRTH: MONTH 7 DAY 23 YEAR 21 — 6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 5 YEAR 1988 — 2d. HOUR 5:22 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): ROCKS, Md — 7b. CITIZEN OF WHAT COUNTRY? USA — 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD.

10. CITY OR TOWN OF DEATH: FALLSTON — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GENERAL HOSPITAL — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Custodian — 12b. KIND OF BUSINESS OR INDUSTRY: Janitorial

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md — 13b. COUNTY: Harford — 13c. CITY OR TOWN: Forest Hill — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: 1324 COOPSTOWN RD. 21050

14. FATHER'S NAME: FIRST ROMAN MIDDLE TURNER LAST

15. MOTHER'S MAIDEN NAME: FIRST GRACE MIDDLE SCOTT LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 218-14-7041

17. INFORMANT: E. O'Steen RN — ADDRESS: Fallston Gen. Hosp-ER

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Richard J. Colfer — TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER — DATE SIGNED 12/5/88

EXAMINER'S NAME (TYPE OR PRINT): _____ ADDRESS: _____

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 12/10/88 — 23c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery — 23d. LOCATION CITY OR TOWN: Forest Hill COUNTY: Harford STATE: MD

24. FUNERAL DIRECTOR NAME: Harkins Funeral Home Inc. — ADDRESS: 600 Main St., Delta, PA — 25a. DATE REC'D. BY REGISTRAR: DEC 09 1988 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landeros

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4 25M BP

DHMH - 17 (VR A15 ME (5))

018332 JAN -6 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please mail Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal from the state. If the medical examiner must be notified of any case marked in Item 21, the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other

BP 10

DHMH - 1650M 1/81 (VRA 15, 4)

FOR 1 - STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

REG. NO. 88 36870

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Daniel | MIDDLE: E. | LAST: Wilson | 2a. DATE OF DEATH MONTH DAY YEAR: Dec 21, 1988 | 2b. HOUR: 4:25 PM | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: SEPTEMBER 22, 1899 | 6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD. | | |
| 10. CITY OR TOWN OF DEATH: Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): (RET) MEAT CUTTER | 12b. KIND OF BUSINESS OR INDUSTRY: FED GOVT. (APG) | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Md. | Harford | Havre de Grace | YES ☒ NO ☐ | 123 N. Stokes St. 21078 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| JOHN | EDWARD | WILSON | LYDIA | | SHENBERGER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 217 01 8156 | ELVA TRIMBLE WILSON, | SAME AS #13e |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF (b): SEVERE CORONARY ARTERY DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c): ATHEROSCLEROSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): AZOTEMIA

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 12-16, 19 88, to 12-21, 19 88, that (I) (we) last saw the deceased alive on 12-21, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Dante M. Monakil | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/22/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DANTE M. MONAKIL | Havre de Grace, Md 21078 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 24DECEMBER88 | WESLEYAN CHAPEL CEMETERY | ABERDEEN, HARFORD CO., MARYLAND |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| MITCHELL-SMITH FUNERAL HOME PA, HAVRE de GRACE, MD 21078 | DEC 23 '88 | Julia Davidson-Randell |

016500 DEC 16 88 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 36871
REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Francis; Middle: [redacted]; Last: Wysong Wysong | 2a. DATE OF DEATH Month/Day/Year: 12-2-88 | 2b. HOUR: 7:35 PM | | | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH Month/Day/Year: April 18, 1901 (4 21 01) | 6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS | If under 1 year: Months / Days | If under 24 hrs: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Bel Air Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD. | | |
| 10. CITY OR TOWN OF DEATH: Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Inspector | 12b. KIND OF BUSINESS OR INDUSTRY: County Government | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | Harford | Bel Air | YES ☒ NO ☐ | 1036 Rock Spring Rd. 21014 |

| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME |
|---|---|
| First: John; Middle: Bond; Last: Wysong | First: Ella; Middle: [redacted]; Last: Grymes |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO | 17. INFORMANT (Signature) 692-5234 ADDRESS |
|---|---|---|---|
| NO | — | 212-16-0660 | Mrs. Mary W. Rigdon, 1320 Rigdon Road, Jarrettsville, Maryland 21084. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) → UNKNOWN: Probably Multifactorial. (see below).
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.
UTI, Hyponatremia, Parkinson's Dz, Seizures 2° to Hyponatremia.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐ (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 11/25, 19 88, to 12/1, 19 88, that (I) (we) last saw the deceased alive on 12/1, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| J.K. Lynch | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/2/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| S. Kevin Lynch, M.D. J.K. LYNCH MD | 620 Boulton St. Bel Air, Md. 21014 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec. 5, 1988 | Rock Spring Episc. Ch. Cem. | Forest Hill, Harford Co., Maryland 21050 |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Joseph William Foster | 50 W. Broadway & Williams St. Bel Air, Maryland 21014 | DEC 02 '88 | Julia Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 20

DHMH - 1650M 1/81 (VRA 15, 4)

20

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR JAN 10 89

88 REG. NO. 36872

1. DECEASED NAME (TYPE OR PRINT) FIRST MARION MIDDLE E. LAST ACKLEY

2a. DATE OF DEATH MONTH 12 DAY 27 YEAR 88 — 2b. HOUR 1:40 P.M.

3. SEX: FEMALE

4. RACE: Caucasian

5. DATE OF BIRTH MONTH 3 DAY 11 YEAR 05

6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. — IF UNDER 1 YEAR MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Trenton, N.J.

7b. CITIZEN OF WHAT COUNTRY? United States

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Howard MD.

10. CITY OR TOWN OF DEATH: Ellicott City

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Bon Secours Extended Care Facility

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: P.G. — 13c. CITY OR TOWN: Laurel — 13d. INSIDE CITY LIMITS? YES XX NO ☐ — 13e. STREET ADDRESS / ZIP CODE: 15812 Wayne Avenue 20707

14. FATHER'S NAME FIRST Antrim MIDDLE V. LAST Errickson

15. MOTHER'S MAIDEN NAME FIRST Carolyn MIDDLE V. LAST Ely

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) n/a — (IF YES, GIVE WAR OR DATES) n/a

16b. SOCIAL SECURITY NO. 135-54-3998

17. INFORMANT: John B. Ackley — ADDRESS: same as 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) metastatic breast ca and lung cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1-2 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: severe ASCVD

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Gary Miller — DEGREE MD — ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED 12/1/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY MILLER

22e. ADDRESS 3460 Ellicott Center Drive, Ellicott City

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation — 23b. DATE 12/28/88 — 23c. NAME OF CEMETERY OR CREMATORY BaltimoreWashingCrematory — 23d. LOCATION CITY OR TOWN Laurel COUNTY P.G. STATE Md.

24. FUNERAL DIRECTOR NAME Fleck Funeral Home, Inc. ADDRESS 7601 Sandy Spring Road Laurel, Md. 20707

25a. DATE REC'D. BY REGISTRAR JAN 3 '89 — 25b. REGISTRAR'S SIGNATURE Julia Davidson Pendree

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

017885 DEC-3 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 36373

1. DECEASED NAME (TYPE OR PRINT): FIRST William MIDDLE LAST Anvender

2a. DATE OF DEATH: MONTH December DAY 26 YEAR 1988 — 2b. HOUR 11:50 P.M.

3. SEX: MALE — 4. RACE: WHITE — 5. DATE OF BIRTH: MONTH 11 DAY 22 YEAR 02 — 6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): ILLINOIS — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] — 9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD COUNTY MD.

10. CITY OR TOWN OF DEATH: COLUMBIA — 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): LORIEN NURSING HOME — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): PRINTER — 12b. KIND OF BUSINESS OR INDUSTRY: ADVERTISING

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND — 13b. COUNTY: HOWARD — 13c. CITY OR TOWN: COLUMBIA — 13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS / ZIP CODE: APT 414 21044 10850 GREEN MOUNTAIN CIRCLE

14. FATHER'S NAME: FIRST JOSEPH MIDDLE LAST ANVENDER — 15. MOTHER'S MAIDEN NAME: FIRST ANNA MIDDLE SKRITKA LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES): ------ — 16b. SOCIAL SECURITY NO.: 346-09-5569 — 17. INFORMANT: EULENE ANVENDER — ADDRESS: COLUMBIA, MD APT414 10850 GREEN MOUNTAIN CIR.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIOPULMONARY COLLAPSE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12/22/88
DUE TO, OR AS A CONSEQUENCE OF (b): SUBENDOCARDIAL MI — 9/87
DUE TO, OR AS A CONSEQUENCE OF (c): GENERALIZED DEBILITATION — 87

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): LARGE DECUBITUS

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — 20a. AUTOPSY? YES [ ] NO [X] — 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — 21f. LOCATION: STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from 11 88 to 12/27 88 that (I) (we) last saw the deceased alive on 11 88, and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Harry Oliver MD — 22e. ADDRESS: 3460 ELLICOTT CENTER DR ELL MD 21043

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: 12/29/88 — 23c. NAME OF CEMETERY OR CREMATORY: EVERGREEN BURIAL PARK — 23d. LOCATION: CITY OR TOWN ROANOKE, COUNTY, STATE VIRGINIA

24. FUNERAL DIRECTOR (NAME, ADDRESS): LEROY M & RUSSELL C WITZKE FUNERAL HOME 5555 TWIN KNOLLS ROAD COLUMBIA, MD 21045

25a. DATE REC'D. BY REGISTRAR — REGISTRAR'S SIGNATURE: DEC 28 1988 Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 (OM 7/84) (VRA 15, 4)

0 1 6 7 4 6 DEC 20 88

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

88 3687 1 REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| ERNEST | E. | ARTER | 12 15 88 | 3 (PM) |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
|---|---|---|---|---|---|
| Male | Black | 08 24 94 | 94 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| West Va | U.S.A. | | HOWARD MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| COOKSVILLE | 14330 Frederick RD | Minister | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MD | Howard | COOKSVILLE | YES ☐ NO ☑ | 14330 FREDERICK RD 21723 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| JOHN | A. | ARTER | JANE | BACKUS | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 219-28-5826 | IRMA W. ARTER (Wife) | SAME AS #13 |

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) AORTIC VALVE INSUFFICIENCY

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

CONGESTIVE HEART FAILURE, CHRONIC PROSTATITIS

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 7/19 19 82, to 12/15 19 88, that (I) (we) last saw the deceased alive on 7/15 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.

22b. SIGNATURE

DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED 12/15/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Evelyn Jackson

22e. ADDRESS 5540 Ten Oaks Rd Clarksville MD

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | 12-19-88 | Bushy Park Cem. | Cooksville, | Howard, | MD |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| George R. Snowden | Rockville, MD 20850 | DEC 19 1988 | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked, or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The pink copy is the carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

018072 JAN 4 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

STATE REGISTRAR

REG. NO. 88 3 6 8 7 5

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Robert | Middle: E. | Last: Austin | 2a. DATE OF DEATH Month: 12 | Day: 19 | Year: 87 | 2b. HOUR: 1:57 PM |
| 3. SEX: Male | 4. RACE: W | 5. DATE OF BIRTH Month: 02 | Day: 05 | Year: 16 | 6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS | If under 1 year: Months / Days | If under 24 hrs: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County MD. | | | |
| 10. CITY OR TOWN OF DEATH: Columbia | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard County General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY: AGENT STEAMSHIP Co. | | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD. | HOWARD | ELLICOTT CITY | YES [ ] NO [X] | 3006 BROOKWOOD RD 21043 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last |
|---|---|
| JOHN W AUSTIN | LILLY WEBSTER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| YES | W.W.II | 212-01-0787 | BONNIE OWENS | 3148 CARDINAL DR. 21157 WESTMINSTER MD |

MEDICAL CERTIFICATION

16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | cardiopulmonary arrest, cardiogenic shock | 48 hrs |
| DUE TO, OR AS A CONSEQUENCE OF (b) | myocardial infarction / possible aspiration | 48 hrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) | pneumonia | 3-4 days |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

9/2

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): severe alcohol abuse x 40 yrs

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Jay Miles | ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] | 12/29/87 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| | |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 12-22-88 | CRESTLAWN | MARRIOTTSVILLE HOWARD MD |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HARRY H. WITZKE INC. 4112 COLUMBIA RD 21043 ELLICOTT CITY MD | DEC 27 '88 | Linda Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The person in charge of interment must sign page 3 and deliver it to the cemetery before removal. If page 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to removal. In the event the medical examiner must be notified at once.

IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be notified at once.

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

D17880 DEC-389

FOR 1 - STATE REGISTRAR DORIS F. BASS

83 REG. NO. 3687 6

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: DORIS | MIDDLE: F. | LAST: BASS | 2a. DATE OF DEATH MONTH DAY YEAR: 12/23/88 12-23-88 | | 2b. HOUR: 1246 PM |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR: 01 02 28 | 6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD COUNTY MD | | |
| 10. CITY OR TOWN OF DEATH: COLUMBIA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOWARD COUNTY GENERAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND | 13b. COUNTY: HOWARD | 13c. CITY OR TOWN: COLUMBIA | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET ADDRESS / ZIP CODE: 5535 SUFFIELD COURT 21044 | |
| 14. FATHER'S NAME FIRST: ELMER | MIDDLE: DORSIE | LAST: FOUT | 15. MOTHER'S MAIDEN NAME FIRST: MARY | MIDDLE | LAST: NICHOLS |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 223-30-5114 | 17. INFORMANT: JEROME E. BASS | ADDRESS: 5535 SUFFIELD COURT COLUMBIA MARYLAND 21044 | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 1/2 hours
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.

22b. SIGNATURE: George Brown M.D. DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED:

22d. PHYSICIAN'S NAME (TYPE OR PRINT): GEORGE S BROWN — 22e. ADDRESS: HOWARD COUNTY GENERAL HOSPITAL

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: 12-28-88 | 23c. NAME OF CEMETERY OR CREMATORY: PEACHTREE MEM. PARK | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: NORCROSS GEORGIA | |
| 24. FUNERAL DIRECTOR (NAME): Wm. Caton Sr. & Co. (ADDRESS): 1630 Edmondson Ave. CATONSVILLE, MD. | | | 25a. DATE REC'D. BY REGISTRAR: DEC 28 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

0157388 DEC 12 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached (please use the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If items 21, 22, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO 88 036877

| | | | | |
|---|---|---|---|---|
| DECEASED NAME (TYPE OR PRINT) FIRST: REBECCA | MIDDLE: | LAST: BEBAR | 2a. DATE OF DEATH MONTH DAY YEAR: DECEMBER 1, 1988 | 2b. HOUR: 11:45 PM |
| 3. SEX: FEMALE | 4. RACE: CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR: NOVEMBER 19, 1913 | 6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MASSACHUSETTS | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH: COLUMBIA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 5159 ENDYMION WAY 21044 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SECRETARY | 12b. KIND OF BUSINESS OR INDUSTRY: MASS. ELECTRIC CO. | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MARYLAND | HOWARD | COLUMBIA | YES ☐ NO ☒ | 5159 ENDYMION WAY 21044 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| ABRAHAM / / BEBAR | MINNIE / / SCHWARTZ |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| NO | 012-05-6976 | LAWRENCE BODIN 5159 ENDYMION WAY 21044 COLUMBIA, MD |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Gastric Cancer.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Chronic anemia, Jaundice, Ascites.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from Oct 19 88 to Dec 19 88, that (I) (we) last saw the deceased alive on Nov 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | 22c. DATE SIGNED |
|---|---|---|---|---|
| | MD | ATTENDING PHYSICIAN ☒ | MEDICAL DIRECTOR ☐ | STAFF PHYSICIAN ☐ | 12/2/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Jon K. Minford, MD | 10806 Hickory Ridge, Col. 21044 |

| 23a. BURIAL, CREMATION, REMOVAL OR OTHER | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| REMOVAL-BURIAL | 12/4/88 | SONS OF JACOB CEMETERY | LEICESTER. MASSACHUSETTS |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | DEC 8 - 1988 | Julia Davidson-Rendall |

018073 JAN 3 1989

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6378

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | FREDERICK / CHARLES / BECKER | | | 2a. DATE KNOWN OF DEATH ESTIMATED ☒ MONTH DAY YEAR | 12-25-88 19 |
| | | | | 2b. HOUR | M |
| 3. SEX | MALE | 4. RACE | WHITE | 5. DATE OF BIRTH MONTH DAY YEAR | NOV. 12, 1913 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 75 YRS. | IF UNDER 1 YR. MONTHS / DAYS | | IF UNDER 24 HRS. HOURS / MIN. | |
| 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR | 12-25-88 19 | 2d. HOUR | 2:45 PM | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | HOWARD COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH | Ellicott City | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 3522 Chatham Road | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | RETIRED MACHINIST |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | MARYLAND | 13b. COUNTY | HOWARD | 13c. CITY OR TOWN | ELLICOTT CITY |
| 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | | 13e. STREET ADDRESS | 3522 Chatham Road 21043 | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | LOUIS HENRY BECKER | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | LYDIA ROSE Unknown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | YES | (IF YES, GIVE WAR OR DATES) | WW 11 | 16b. SOCIAL SECURITY NO. | 213 05 3527 |
| 17. INFORMANT | M's Clara Sheets | ADDRESS | 10720 Frederick Rd 21043 | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hanging
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☒ NO ☐ |
| 21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: 12-88 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): subject hanged self |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): basement | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE: 3522 N. Chatham Rd. Ellicott City, Maryland |

22a. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Mario F. Golle, Jr. M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED 12-26-88

EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. ADDRESS 111 Penn Street

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (CIRCLE) | Burial | 23b. DATE | Dec. 29, 1988 |
| 23c. NAME OF CEMETERY OR CREMATORY | Good Shepherd | 23d. LOCATION CITY OR TOWN / COUNTY / STATE | Ellicott City Howard Maryland |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | Harry H Witzke 4112 Columbia Pike Ellicott City | 25a. DATE REC'D. BY REGISTRAR | DEC 27 '88 |
| 25b. REGISTRAR'S SIGNATURE | Lidia Davidson-Randall | | |

07/84 25M BP 10

DHMH - 17 (VR A15 ME (5))

018071 JAN 14 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO 88 036879

1. DECEASED NAME (TYPE OR PRINT): FIRST Gwendoline MIDDLE E. LAST BEST

2a. DATE OF DEATH: MONTH 12 DAY 24 YEAR 88 — 2b. HOUR 835 AM

3. SEX: F Female

4. RACE: C White

5. DATE OF BIRTH: MONTH 03 DAY 04 YEAR 09

6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): England

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑

9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD, COUNTY MD.

10. CITY OR TOWN OF DEATH: COLUMBIA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOWARD COUNTY

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Howard — 13c. CITY OR TOWN: Ellicott City — 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e. STREET ADDRESS / ZIP CODE: 9426 Brookmede Court 21043

14. FATHER'S NAME: FIRST Hubert MIDDLE Percie LAST Jarvis Smith

15. MOTHER'S MAIDEN NAME: FIRST Emma MIDDLE Sophia LAST Daines

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 220 56 7544

17. INFORMANT: Mrs Audrey Rees — ADDRESS: 9426 Brookmede Court 21043

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIOPULMONARY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF

(b): BILATERAL CEREBROVASCULAR ACCIDENTS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: HYPERTENSION, LIVER FAILURE, DIABETES MELLITUS

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2):

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION: STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec 3, 19 88, to Dec 24, 19 88, that (I) (we) last saw the deceased alive on Dec 23, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Lynne A. Gaynes — DEGREE: M.D. — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12/24/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): LYNNE A. GAYNES M.D.

22e. ADDRESS: 14201 LAUREL PARK DR LAUREL MD 20707

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation — 23b. DATE: DEc 26, 1988 — 23c. NAME OF CEMETERY OR CREMATORY: Westview Memorial Pk — 23d. LOCATION: CITY OR TOWN Catonsville — COUNTY Balto., — STATE Md.

24. FUNERAL DIRECTOR: NAME Harry H Witzke — ADDRESS 4112 Old Columbia Pike Ellicott City

25a. DATE REC'D. BY REGISTRAR: DEC 27 '88

25b. REGISTRAR'S SIGNATURE:

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 16 60M 7/84 (VRA 15, 4)

17040 DEC 22 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 036880

1. DECEASED NAME (TYPE OR PRINT): FIRST VADNA MIDDLE D. LAST BROWN
2a. DATE OF DEATH: MONTH 12 DAY 13 YEAR 88
2b. HOUR: M
3. SEX: F
4. RACE: W
5. DATE OF BIRTH: MONTH 9 DAY 17 YEAR 17
6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): OHIO
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD MD.
10. CITY OR TOWN OF DEATH: COLUMBIA
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 5551 HIGH TOR HILL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: HOWARD
13c. CITY OR TOWN: COLUMBIA
13d. INSIDE CITY LIMITS? YES [ ] NO [ ]
13e. STREET ADDRESS / ZIP CODE: 5551 HIGH TOR HILL 21045

14. FATHER'S NAME: FIRST WILLIAM MIDDLE LAST DENNIS
15. MOTHER'S MAIDEN NAME: FIRST ALMA MIDDLE LAST WILLIAMS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.:
17. INFORMANT: HARRY A. BROWN ADDRESS: 5551 HIGH TOR HILL COLUMBIA MD 21045

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): metastatic ovarian carcinoma.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION: N/A
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2):
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from January 19 86 to December 13 88 that (I) (we) last saw the deceased alive on November 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: William Fawcett MD
DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 12/14/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): William Flowers MD
22e. ADDRESS: Columbia Medical Center

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION
23b. DATE: 12-14-88
23c. NAME OF CEMETERY OR CREMATORY: WESTVIEW
23d. LOCATION: CITY OR TOWN CATONSVILLE COUNTY BALTIMORE STATE MD

24. FUNERAL DIRECTOR: HARRY H. WITZKE FUNERAL HOME, INC
ADDRESS: 4112 OLD COLUMBIA PIKE ELLICOTT CITY MD 21043
25a. DATE REC'D BY REGISTRAR: DEC 16 88
25b. REGISTRAR'S SIGNATURE: Linda Davidson-Randall

IMPORTANT: If Item 21a is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 15

DHMH - 16 60M 7/84
(VRA 15, 4)

HARRY N. WITZKE
FUNERAL HOME, INC

4113 OLD COLUMBIA PIKE
ELLICOTT CITY MD 21043

016331 DEC 15 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36881 REG. NO.

1. DECEASED NAME — FIRST: Dorothy (Dorothy) MIDDLE: C. LAST: Colley (Colley)

2a. DATE OF DEATH — MONTH: 12 DAY: 1 YEAR: 88 — 2b. HOUR: 10:40 AM

3. SEX: Female — 4. RACE: Caucasian — 5. DATE OF BIRTH: 02 02 13 — 6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Alabama — 7b. CITIZEN OF WHAT COUNTRY?: USA (USA) — 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Howard MD.

10. CITY OR TOWN OF DEATH: Columbia Md — 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard Co General Hosp — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HS Wife — 12b. KIND OF BUSINESS OR INDUSTRY: G.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD. — 13b. COUNTY: Howard — 13c. CITY OR TOWN: Jessup. — 13d. INSIDE CITY LIMITS? YES ☐ NO ☑ — 13e. STREET ADDRESS / ZIP CODE: 8295 Rt. 34 Rte 20794

14. FATHER'S NAME — FIRST: Nallen — MIDDLE — LAST: McWaters — 15. MOTHER'S MAIDEN NAME — FIRST: Ader — MIDDLE — LAST: Campbell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No. — (IF YES, GIVE WAR OR DATES): N/A — 16b. SOCIAL SECURITY NO.: 420-22-6926 (420-22-6926) — 17. INFORMANT: Arthur M. Jones — ADDRESS: 630 Foley Lane Prince Frederick Md20678

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD
DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

I888

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Bronchogenic CA (L) Lung;

19a. DATE OF OPERATION: 1.14.88 — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Fx (L) Hip — 20a. AUTOPSY? YES ☐ NO ☑ — 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☑ — 21b. TIME OF INJURY: HOUR A.M. P.M. — MONTH: 11-1-88 DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2): Fall @ Home

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.): Home. — 21f. LOCATION: STREET: 8295 Lot 34 — CITY OR TOWN: Rte 1 Jessup — COUNTY: Howard — STATE

22a. I certify that (I) (this hospital) attended the deceased from 11-1-88, 19____, to 12-1, 19 88, that (I) (we) last saw the deceased alive on 11-30-88, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Dwight Rowe Md — DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12-1-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): George F. Rowe — 22e. ADDRESS: M.D. II Knox Manor, Col. Md. 21045

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 12/03/88 — 23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery — 23d. LOCATION: Brentwood Prince George's Md.

24. FUNERAL DIRECTOR (NAME): Lee Funeral Home, Inc. — 6633 Old Alexander Ferry Rd Clinton, Md 20735

25a. DATE REC'D BY REGISTRAR: DEC 09 1988 — 25b. REGISTRAR'S SIGNATURE: Linda Lindon-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

018070 JAN -4 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO. 3 6 3 8 2

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 4

DHMH-16 30M 2/80 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
| | OSCAR | CLARENCE | COLLEY | 12-20-88 12/20/88 | 735 am |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR: MONTHS DAYS | IF UNDER 24 HRS.: HOURS MIN. |
| MALE | WHITE | 05 18 22 | 66 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| GEORGIA | U.S.A. | | HOWARD COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| COLUMBIA | HOWARD COUNTY GENERAL HOSPITAL | | MECHANIC | AUTOMOBILE | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MARYLAND | HOWARD | JESSUP | YES ☐ NO ☒ | 8295-34 WASHINGTON BLVD. 20794 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| THOMAS | | COLLEY | NELLA | ANN | ILER |

| 16a. DECEASED EVER IN U.S. ARMED FORCES? (IF YES OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | KOREAN | 259-10-6145 | DOUGLAS COLLEY | 770 WILLIAM ST. DACULA, GA 30211 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Intestinal pseudoobstruction, Barbiturate dependency

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I) (this hospital) attended the deceased from 11-25 19 88 to 12-20 19 88, that (I) (we) last saw the deceased alive on 12-19 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Parry A Moore MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/20/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| PARRY A. MOORE M.D. | 2 KNOLL NORTH DRIVE COLUMBIA, MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| BURIAL | 12/24/88 | HUFF CEMETERY | WATKINSVILLE OCONEE GEORGIA |

| 24. FUNERAL DIRECTOR (NAME) | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| LEROY M & RUSSELL C WITZKE FUNERAL HOME | 5555 TWIN KNOLLS ROAD COLUMBIA, MD 21045 | DEC 23 '88 | Julia Davidson-Randall |

018207 JAN 5 89

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

33 REG. NO. 3 6 8 8 3

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or asked to determine by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Elroy | MIDDLE | LAST: Cook, Sr. | 2a. DATE OF DEATH MONTH DAY YEAR: 12 - 27 - 88 |
| 2b. HOUR: M | | | |
| 3. SEX: Male | 4. RACE: Black | 5. DATE OF BIRTH MONTH DAY YEAR: 01 - 19 - 15 | 6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS. |
| IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County MD. |
| 10. CITY OR TOWN OF DEATH: Columbia | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard County General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Machinest | 12b. KIND OF BUSINESS OR INDUSTRY: Construction |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13a. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Howard | West Friendship | YES [ ] NO [X] | 2885 Route 32 21797 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Raymond | | Cook | Rachel | | McCullah |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | ------ | 218-12-7283 | Ida Williams | Cooksville, MD 21723 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1/2 hour

DUE TO, OR AS A CONSEQUENCE OF

(b) Coronary Artery Disease — 3+ years

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Aortic Stenosis

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Jeffrey J. Cole, M.D. | ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Dr. Jeffrey Cole, M.D. | 3455 Wiltens Ave 21229 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12-31-88 | Bushy Park Cemetery | Cooksville / Howard / MD |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HAIGHT FUNERAL HOME Sykesville, MD 21784 | JAN 3 1989 | Lucia Davidson-Randall |

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

017788 DEC 30 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 3 6 8 8 5

1. DECEASED NAME (TYPE OR PRINT) — FIRST: JAMES — MIDDLE: U — LAST: ESTEP

2a. DATE OF DEATH — MONTH: 12 — DAY: 23 — YEAR: 88

2b. HOUR: 1:30 PM

3. SEX: Male

4. RACE: BLACK

5. DATE OF BIRTH — MONTH: 10 — DAY: 21 — YEAR: 32

6. AGE (IN YEARS LAST BIRTHDAY): 56 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD COUNTY MD.

10. CITY OR TOWN OF DEATH: COLUMBIA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOWARD COUNTY Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Unemployed

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md — 13b. COUNTY: Montg. — 13c. CITY OR TOWN: Silver Spring — 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] — 13e. STREET ADDRESS / ZIP CODE: 15811 Kadwick Lane / 20906

14. FATHER'S NAME — FIRST: Alvin — MIDDLE: — LAST: Clark

15. MOTHER'S MAIDEN NAME — FIRST: Mary — MIDDLE: J. — LAST: Estep

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 219-28-1335

17. INFORMANT — NAME: Mary J. Myers (mother) — ADDRESS: 7951 Guilford Rd Columbia, MD 21044

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): esophageal varicial hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 15 hours
DUE TO, OR AS A CONSEQUENCE OF (b): cirrhosis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2):

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Edward J. Levine — DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 12/23/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): EDWARD J. LEVINE

22e. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 12-27-88

23c. NAME OF CEMETERY OR CREMATORY: Hopkins Cemetery

23d. LOCATION — CITY OR TOWN: Highland — COUNTY: Howard — STATE: MD

24. FUNERAL DIRECTOR — NAME: George R. Snowden — ADDRESS: Rockville, MD 20850

25a. DATE REC'D. BY REGISTRAR: DEC 28 1988

25b. REGISTRAR'S SIGNATURE:

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

018425 JAN 89

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO. 36886

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | WILLIAM LUMSDEN FEARING | 2a. DATE OF DEATH MONTH DAY YEAR | DEC. 31, 1988 | 2b. HOUR | 2 P M |
| 3. SEX | MALE | 4. RACE | WHITE | 5. DATE OF BIRTH MONTH DAY YEAR | JUNE 13 1908 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 80 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | NORTH CAROLINA | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | HOWARD COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH | ELLICOTT CITY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 4445 STONECREST DRIVE | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | PHYSICIAN |
| 12b. KIND OF BUSINESS OR INDUSTRY | GEN. PRACTICE | | | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MARYLAND | HOWARD | ELLICOTT CITY | YES ☐ NO ☒ | 4445 STONECREST DR. 21043 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | ISAIAH FEARING | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | SUSAN DAVIS |
|---|---|---|---|

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| YES | 1942-1946 | 215-30-3682 | HELEN F. IRWIN | 4441 STONECREST DR. ELLICOTT CITY, MD. 21043 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of prostate — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 14 mos

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Cord compression Metastasis to Bone - spine

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☒ NO ☐ | YES ☒ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 10/5, 19 82, to 12/31, 19 88, that (I) (we) last saw the deceased alive on ~~12/17~~ 12/5, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Wm. F. Fearing — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 1/3/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Wm. F Fearing — 22e. ADDRESS: 3222 St Paul St 21218

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 4 JAN 89 | ST. JOHN'S CEMETERY | ELLICOTT CITY / HOWARD / MD. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| SLACK FUNERAL HOME | ELLICOTT CITY, MD 21043 | JAN 5 1989 | Julia Davidson-Kendall |

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, an other traumatic event, the medical examiner shall be contacted prior to

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DHMH - 16 60M 7/84 (VRA-15, 4)

017042 DEC 22 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO 88 336887

1. DECEASED NAME (TYPE OR PRINT): FIRST Claudia; MIDDLE; LAST Frazier

2a. DATE OF DEATH: MONTH 12; DAY 12; YEAR 88

2b. HOUR: 2.10 P M

3. SEX: Female

4. RACE: WHITE

5. DATE OF BIRTH: MONTH 09; DAY 27; YEAR 39

6. AGE (IN YEARS LAST BIRTHDAY): 49 YRS

IF UNDER 1 YEAR: MONTHS; DAYS

IF UNDER 24 HRS.: HOURS; MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD.

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County MD.

10. CITY OR TOWN OF DEATH: Columbia

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard County General Hosp

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SECRETARY

12b. KIND OF BUSINESS OR INDUSTRY: BENDIX

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD.

13b. COUNTY: Balt.

13c. CITY OR TOWN: Catonsville

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 8126 FOREVER GREEN CT. 21227

14. FATHER'S NAME: FIRST Rhonda; MIDDLE; LAST TRIPLETT

15. MOTHER'S MAIDEN NAME: FIRST Mary; MIDDLE Ruth; LAST Sommerville

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): —

16b. SOCIAL SECURITY NO.: 217-38-7130

17. INFORMANT: Melanie Frazier

ADDRESS: 8126 Forevergreen Ct. Caton. 21227

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiogenic Shock

DUE TO, OR AS A CONSEQUENCE OF (b): Congestive Cardiomyopathy.

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

Breast CA metastatic to lung, Chronic Anemia, S/P V. Fibrillation.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from Oct 19 81, to Dec 19 88, that (I) (we) last saw the deceased alive on Dec 12 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Jon K. Minfield

DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12-13-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Minfield, Jon K

22e. ADDRESS: 10806 Hickory Ridge Rd, Columbia, MD, 21044

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 12-15-88

23c. NAME OF CEMETERY OR CREMATORY: MEADOWRIDGE MEM.

23d. LOCATION: CITY OR TOWN Elkridge; COUNTY Balt.; STATE MD.

24. FUNERAL DIRECTOR: NAME SLACK FH-PO BOX 268 E.C.; ADDRESS 21043

25a. DATE REC'D BY REGISTRAR: DEC 16 '88

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Mandell

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 20

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

88 REG. NO. 36388

017850 DEC 88

1. DECEASED NAME (TYPE OR PRINT): John J. Garrett
2a. DATE OF DEATH: Dec. 22, 1988
2b. HOUR: 930 M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: Aug. 2, 1910
6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Balto. City
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Howard Co. Md. MD.
10. CITY OR TOWN OF DEATH: Normandy
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 3262-B Normandy Woods Drive
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Truck Driver
12b. KIND OF BUSINESS OR INDUSTRY: Dept. Stores

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md.
13b. COUNTY: Howard
13c. CITY OR TOWN: Normandy
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS: 3262-B Normandy Drive 21043

14. FATHER'S NAME: John R. Garrett
15. MOTHER'S MAIDEN NAME: Anne Daniels
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): yes
(IF YES, GIVE WAR OR DATES): II
16b. SOCIAL SECURITY NO.: 217-07-3909
17. INFORMANT: Mrs. Ruth R. Garrett
ADDRESS: 3262- B Normandy Woods Drive Ellicott City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest — Sudden
DUE TO, OR AS A CONSEQUENCE OF
(b): Ventricular Arrhythmia — months
DUE TO, OR AS A CONSEQUENCE OF
(c): Coronary Artery disease — years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/15 19 88 to June 19 88 to 12/22 19 88, that (I) (we) last saw the deceased alive on 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (He was not) (did not) view the body after death.
22b. SIGNATURE
DEGREE: MD
ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 12-22-88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Jerry F. Lescure, MD
22e. ADDRESS: 11055 Little Patuxent Pkwy, Columbia, Md

23a. BURIAL, CREMATION, REMOVAL (SPEC#Y): Burial
23b. DATE: Dec. 24, 1988
23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
23d. LOCATION CITY OR TOWN: Balto. COUNTY: Md. STATE
24. FUNERAL DIRECTOR NAME: G. Trenor Schuab ADDRESS: 5151 Baltimore National Pike
25a. DATE REC'D. BY REGISTRAR: DEC 28 1988
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, an item 18 shows any injury, or other traumatic event, the medical examiner must be notified by one of the following methods:

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

015690 DEC 1988

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36889 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked on Item 18 show any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: George | MIDDLE: — | LAST: Gillam | 2a. DATE OF DEATH MONTH DAY YEAR: 11 26 88 | 2b. HOUR: 0840A | |
| 3. SEX: M | 4. RACE: Black | 5. DATE OF BIRTH MONTH DAY YEAR: 02 07 10 | 6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County (MD) | | |
| 10. CITY OR TOWN OF DEATH: Columbia | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard County Gen Hosp. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): — | 12b. KIND OF BUSINESS OR INDUSTRY: — | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | Howard | Columbia | YES ☒ NO ☐ | 9625 Whiteacre RD 21045 |

| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |
|---|---|
| | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| | | 577506490 | Ronald Jones-9625 Whiteacre Rd. Columbia, Md. 21045 |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiopulmonary Arrest. | 1 HR |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Pneumonia, Chronic bilat subdural hematomas.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| — | — | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 11/20 19 88 to 11/26 19 88, that (I) (we) last saw the deceased alive on 11/25 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
|---|---|---|---|
| Bruce M. Conger | MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 11/26/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| B M CONGER MD | 11055 LITTLE PATUXENT HGWY #104 ; COLUMBIA MD 21044 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Removal | 12-6-88 | | |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| State Anatomy Board | Balto., Md. | DEC 7 1988 | Julia Davidson-Rogers |

017820 DEC 30 88 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 036390 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified above.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Fannie | Middle: Elizabeth | Last: Hall | 2a. DATE OF DEATH Month/Day/Year: 12/9/88 | 2b. HOUR: 845 M | |
| 3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH Month/Day/Year: 12/31/00 | 6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS | If under 1 year: Months / Days | If under 24 hrs: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Watersville, Md. | 7b. CITIZEN OF WHAT COUNTRY?: US | 8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Howard MD. | | |
| 10. CITY OR TOWN OF DEATH: Columbia | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard County Gen. Hosp | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Howard | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Howard | 13c. CITY OR TOWN: Savage | 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ | 13e. STREET ADDRESS: 8428 Woodward Street 20763 | |
| 14. FATHER'S NAME First: Louis | Middle: A. | Last: Hall | 15. MOTHER'S MAIDEN NAME First: Blanche | Middle: E. | Last: Hatfield |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): n/a | (IF YES, GIVE WAR OR DATES): n/a | 16b. SOCIAL SECURITY NO.: 212-52-2768 | 17. INFORMANT: Robert W. Hall | ADDRESS: same as 13e | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | Approximate interval between onset and death |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiopulmonary arrest | 2 hours |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Hypertensive heart disease | Years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this ~~hospital~~) attended the deceased from 12/9, 1988, to _____, 19____, that (I) (we) last saw the deceased alive on 12/9, 19 88, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (~~did not~~) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: Charles G Taylor MD | DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12-9-88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Charles G Taylor MD | 22e. ADDRESS: 2 Knoll North Drive Columbia MD 21045 | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/13/88 | 23c. NAME OF CEMETERY OR CREMATORY: Poplar Springs Cem. | 23d. LOCATION CITY OR TOWN: Poplar Springs | COUNTY: Howard STATE: Md. |
| 24. FUNERAL DIRECTOR NAME AND ADDRESS: Fleck Funeral Home, Inc. 7601 Sandy Spring Rd. Laurel, Md. 20707 | | 25a. DATE REC'D BY REGISTRAR: DEC 21 88 | 25b. REGISTRAR'S SIGNATURE: [illegible] | |

R BP 7

DHMH - 16 50M 1/81 (VRA 15, 4)

016095 DEC 14

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36891 REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST DORIS MIDDLE M. LAST HANESCHLAGER
2a. DATE OF DEATH: MONTH 12 DAY 8 YEAR 88
2b. HOUR: 5:23 PM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: MONTH 8 DAY 03 YEAR 18
6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD.
10. CITY OR TOWN OF DEATH: Columbia
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard County General Hosp.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker
12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Howard
13c. CITY OR TOWN: Ellicott City
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: 3354-E Chatham Rd. 21043

14. FATHER'S NAME: FIRST Francis MIDDLE C. LAST Rivers
15. MOTHER'S MAIDEN NAME: FIRST Elizabeth MIDDLE C. LAST O'Connell
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 216-03-3042
17. INFORMANT: James F. Haneschlager - 12865 Folly Qtr.Rd. ADDRESS: Ellicott City 21043

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiogenic Shock | 12 hrs |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Myocardial Infarction | 12 hrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) | ASCVD | Many yrs |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Renal Failure / Hepatic Failure -

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Oct 19 88 to 12/9 19 88, that (I) (we) last saw the deceased alive on 12/5 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/8/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. ROSS
22e. ADDRESS: Columbia, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 12-12-88
23c. NAME OF CEMETERY OR CREMATORY: St. Joseph Fullerton
23d. LOCATION: CITY OR TOWN Fullerton COUNTY Balto. STATE Md.

24. FUNERAL DIRECTOR NAME AND ADDRESS: Ruck Towson Funeral Home, Inc., 1050 York Rd. Towson, Md. 21204
25a. DATE REC'D BY REGISTRAR: DEC 12 1988
25b. REGISTRAR'S SIGNATURE: [signature] Harrison-Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

015976 DEC 13 08

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 036892 REG. NO

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Ekelle | MIDDLE: N | LAST: Harrid HARRID | 2a. DATE OF DEATH MONTH: 12 | DAY: 6 | YEAR: 88 |
| 2b. HOUR: 1 P M | | | | | |
| 3. SEX: Male | 4. RACE: Black | 5. DATE OF BIRTH MONTH: 11 | DAY: 22 | YEAR: 48 | 6. AGE (IN YEARS LAST BIRTHDAY): 40 YRS. |
| IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH: HOWARD CO. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOWARD COUNTY GENERAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE: MARYLAND | 13b. COUNTY: HOWARD | 13c. CITY OR TOWN: HOWARD CO. | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS / ZIP CODE: 7208 SLEEP SOFT CIR. 21045 | |
| 14. FATHER'S NAME FIRST: NATHAN MIDDLE: | LAST: HARRID | 15. MOTHER'S MAIDEN NAME FIRST: CORA MIDDLE: E. | LAST: NORVILLE | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 213-52-1238 | 17. INFORMANT: JEAN HARRID | ADDRESS: 7208 SLEEP SOFT CIRCLE | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): AIDS

DUE TO, OR AS A CONSEQUENCE OF

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CMV retinitis

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 12/1 19 88 to 12/6 19 88, that (I) (we) last saw the deceased alive on 12/6 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|
| Gary Brooks | | 12/6/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Gary Brooks | 22e. ADDRESS: 11015 Little Patuxent | |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: 12/10/88 | 23c. NAME OF CEMETERY OR CREMATORY: Maryland National | 23d. LOCATION CITY OR TOWN: Laurel COUNTY: Md. STATE: |
|---|---|---|---|
| 24. FUNERAL DIRECTOR NAME / ADDRESS: LEROY O. DYETT 4600 LIBERTY HGTS AVENUE | 25a. DATE REC'D. BY REGISTRAR: DEC 09 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Lindsay | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completely filled in by the funeral director within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

017887 DEC -3 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR BEATRICE RUTH HARRIS

88 REG. NO. 36893

1. DECEASED NAME (TYPE OR PRINT): First Beatrice Middle RUTH Last Harris
2a. DATE OF DEATH: Month 12 Day 24 Year 88
2b. HOUR: 3A M
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: Month 04 Day 25 Year 17
6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD COUNTY MD.
10. CITY OR TOWN OF DEATH: COLUMBIA
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN EITHER, GIVE STREET ADDRESS): HOWARD COUNTY GENERAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE
12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY: HOWARD
13c. CITY OR TOWN: COLUMBIA
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS / ZIP CODE: 7250 C EDEN BROOK DR. APT 101 21046

14. FATHER'S NAME: First CHARLES Middle Last DANZIGER
15. MOTHER'S MAIDEN NAME: First ROSE Middle Last SHIMKIN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 130-09-9097
17. INFORMANT: DAVID HARRIS ADDRESS: 9856 SOFT WATER WAY COLUMBIA MARYLAND 21046

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ventricular fibrillation — Approximate interval between onset and death: Minutes
DUE TO, OR AS A CONSEQUENCE OF (b): Acute myocardial infarction — 10 days.
DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic heart disease — years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Metabolic Acidosis. Diabetes Mellitus Renal failure

19a. DATE OF OPERATION: NONE
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2): NONE
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec. 6 19 88 to Dec 24 19 88, that (I) we) last saw the deceased alive on Dec 23 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: William Parnes DEGREE: M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12-24-88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): WILLIAM PARNES
22e. ADDRESS: 11085 LITTLE PATUXENT PKWY COLUMBIA MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: 12/28/88
23c. NAME OF CEMETERY OR CREMATORY: MT. LEBANON CEMETERY
23d. LOCATION: CITY OR TOWN GLENDALE COUNTY NEW YORK STATE

24. FUNERAL DIRECTOR: LEROY M & RUSSELL C WITZKE FUNERAL HOME
5555 TWIN KNOLLS ROAD COLUMBIA MD 21045
25a. DATE REC'D. BY REGISTRAR: DEC 28 1988
REGISTRAR'S SIGNATURE: Julia Davidson-Ponder

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

016445 DEC 15 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 3 6 8 9 4 REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and shall retain jurisdiction.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Robert | MIDDLE: Cupid | LAST: Harrison | 2a. DATE OF DEATH MONTH DAY YEAR: 12-8-88 | 2b. HOUR: 10p M | |
| 3. SEX: Male | 4. RACE: Black | 5. DATE OF BIRTH MONTH DAY YEAR: 8 18 26 | 6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS | IF UNDER 1 YEAR MONTHS DAYS: | IF UNDER 24 HRS. HOURS MIN.: |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD MD. | | |
| 10. CITY OR TOWN OF DEATH: Columbia, Md. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard County General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Maintenance | 12b. KIND OF BUSINESS OR INDUSTRY: | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md. | 13b. COUNTY: Howard | 13c. CITY OR TOWN: Columbia | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS / ZIP CODE: 6200 Foreland Court 21045 | |
| 14. FATHER'S NAME FIRST: William | MIDDLE: | LAST: HARRISON | 15. MOTHER'S MAIDEN NAME FIRST: Rosie | MIDDLE: Blue | LAST: |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes | (IF YES, GIVE WAR OR DATES): WWII | 16b. SOCIAL SECURITY NO.: 226-36-4922 | 17. INFORMANT: Diane Harrison | ADDRESS: 9650 White Acre Rd. Columbia MD | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Bacterial Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b): Carcinoma of base of tongue
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Anorexia / Cachexia Syndrome, Prerenal azotemia, Chronic anemia

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from March 19 88, to Dec 19 88, that (I) (we) last saw the deceased alive on Dec 8 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Jon K. Minford | DEGREE: MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12-9-88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Jon K. Minford | 22e. ADDRESS: 10806 Hickory Ridge Rd Columbia, MD 21044 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12-13-88 | 23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery | 23d. LOCATION CITY OR TOWN: Laurel | COUNTY: Anne Arundel | STATE: MD |
| 24. FUNERAL DIRECTOR NAME: George R. Snowden | ADDRESS: Rockville, MD 20850 | 25a. DATE REC'D. BY REGISTRAR: DEC 14 1988 | 25b. REGISTRAR'S SIGNATURE: | | |

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

16981 DEC 22 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 036895

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this form be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST Nellie | MIDDLE C. | LAST Hartke |
| 2a. DATE OF DEATH | MONTH Dec. | DAY 17, | YEAR 1988 |
| 2b. HOUR | 12p M | | |
| 3. SEX | Female | | |
| 4. RACE | White | | |
| 5. DATE OF BIRTH | MONTH 4 | DAY 28 | YEAR 1913 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 75 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Maryland | | |
| 7b. CITIZEN OF WHAT COUNTRY? | USA | | |
| 8. | MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Howard County MD. | | |
| 10. CITY OR TOWN OF DEATH | Elkridge | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 5900 Augustine Ave. | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Supervisor | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | U S Gov't. | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Howard | Elkridge | YES ☐ NO ☒ | 5900 Augustine Ave. 21227 |

| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME |
|---|---|
| FIRST Charles MIDDLE A. LAST Hartke | FIRST Ida MIDDLE M. LAST Furley |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 217 44 0059 | Lester W. Hartke | 6108 Old Washington Rd. 21227 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE CARDIOPULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF (b) ATRIAL FIBRILLATION

DUE TO, OR AS A CONSEQUENCE OF (c) MITRAL VALVE PROLAPSE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: HYPERTENSION

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| — | — | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | — |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) this hospital) attended the deceased from 8/8, 1987, to 12/17, 1988, that (I) (we) last saw the deceased alive on 6/2, 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Soon J. Kim, M.D. | M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/17/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Soon J. Kim | 5808 Main St. Elkridge, Md. 21227 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | 12/19/88 | Loudon Park Crematory | Baltimore, Maryland 21229 |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Gary E. Kaufman 5695 Main St. Elkridge, Md. 21227 | DEC 20 1988 | Julia Davidson-Kapatos |

017239 DEC 2760

FOR 1- STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3396

| 1. DECEASED NAME (TYPE OR PRINT) | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH KNOWN ☐ ESTIMATED XX | MONTH | DAY | YEAR | 2b. HOUR |
|---|---|---|---|---|---|---|---|---|
| | Donald | Leroy | Hartung | | 12- | 17- | 88 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH | DAY | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. | 2c. DATE PRONOUNCED DEAD MONTH | DAY | YEAR | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| M | Cauc | 9/29/ | 47 | | 41 YRS. | | | | | 12-18- | 19 | 88 | 10:50 A M |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED XX | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Md | USA | | Howard County MD |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Ellicott City | Normandy Woods Apartments | Electrician | |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | 21043 |
|---|---|---|---|---|---|
| Md | Howard | Ellicott City | YES ☐ NO ☐ | 3251 Normandy Woods Dr. | |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Frederick | A. | Hartung | Meda | | Nunamaker |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS 21043 |
|---|---|---|---|---|
| yes | Vietnam | 212-46-0531 | Meda Kelly | 3251 Normandy Woods Dr. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute carbon monoxide intoxication

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES XX NO ☐ |

| 21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| | 12-17-88 | Subject inhaled carbon monoxide fumes |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ XX | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | trailer storage lot | Normandy Woods Apartments, | | Howard County, | MD |

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Noturol causes ☐, Accident ☐, Suicide XX, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Margarita A. Korell TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER DATE SIGNED 12-18-88

VC EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | 12/22/88 | Pleasant View Ch of Bretheran Cemetery | Burkittsville | | Md |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Sterling Ashton Funeral Estate, PA | 736 Edmondson Ave | DEC 21 1988 | |

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

0167 17 DEC 20 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

88 REG. NO 036897

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, medical examiner must be notified.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (First, Middle, Last): STELLA J. HELINSKI | | | 2a. DATE OF DEATH (Month - Day, Year): 12-12-1988 |
| 3. SEX: F | 4. RACE: W | 5. DATE OF BIRTH (Month, Day, Year): 9-28-1901 | 6. AGE (In years last birthday): 87 YRS |
| 7a. BIRTHPLACE (State or Foreign Country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: ELLICOTT City How MD. |
| 10. CITY OR TOWN OF DEATH: ELLICOTT CITY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address): 10380 LOMBARDI DR. ELLICOTT City MD. 21043 | | 12a. USUAL OCCUPATION (Type of work for most of working life): HOME MAKER |
| | | | 12b. KIND OF BUSINESS OR INDUSTRY: HOME |

USUAL RESIDENCE (If nursing home or other institution, give residence before admission)

| | | | | |
|---|---|---|---|---|
| 13a. STATE: MD | 13b. COUNTY: — | 13c. CITY OR TOWN: BALTO. | 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ | 13e. STREET ADDRESS / ZIP CODE: 2225 PELHAM AVE. 21213 |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME (First, Middle, Last): STANLEY GROMACKI | | 15. MOTHER'S MAIDEN NAME (First, Middle, Last): UNKNOWN | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown): No | (If yes, give war or dates): — | 16b. SOCIAL SECURITY NO.: 213-44-9959 | 17. INFORMANT: Mrs. Audrey Crook ADDRESS: 10380 Lombardi Dr. Ellicott City MD 21043 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (a) | Thyroid Carcinoma, Widespread metastases (LUNG + BONE) | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Generalized osteoporosis & recent spinal compression fracture

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | |
|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY Hour A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in item 18 Part I or Part 2) |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (At home, street, factory, office, farm, etc.) | 21f. LOCATION Street / City or Town / County / State |

22a. I certify that (I) (this hospital) attended the deceased from 8/2 19 88 to 12/12/ 19 88 that (I) (we) last saw the deceased alive on 11/22/88 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: B Cooper MD | DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12/14/88 |
| 22d. PHYSICIAN'S NAME (Type or Print): BRAD J. COOPER, M.D. | 22e. ADDRESS: 2850 NORTH RIDGE RD. ELLICOTT CITY, MD. 21043 | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: 12-16-1988 | 23c. NAME OF CEMETERY OR CREMATORY: HOLY ROSARY CEM. | 23d. LOCATION City or Town: BALTO. County: MD. State: | |
| 24. FUNERAL DIRECTOR Name: Hartley Miller Funeral Home | Address: 7527 Harford Rd. 21234 | 25a. DATE REC'D. BY REGISTRAR: DEC 15 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landers | |

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

RECEIVED
2021 COLLOM ETHER

017041 DEC 22 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO 88 036893

1. DECEASED NAME (TYPE OR PRINT) — FIRST: BARBARA — MIDDLE: H. — LAST: HOPPNER
2a. DATE OF DEATH — MONTH DAY YEAR: DECEMBER 14 1988
2b. HOUR: M
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH — MONTH DAY YEAR: 02 19 06
6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS: HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): GERMANY
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD COUNTY MD
10. CITY OR TOWN OF DEATH: COLUMBIA
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 9079 WILD APPLE COURT
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER
12b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY: HOWARD
13c. CITY OR TOWN: COLUMBIA
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 9079 WILD APPLE CT. 21045

14. FATHER'S NAME — FIRST: JOHANN — MIDDLE — LAST: HERMANN
15. MOTHER'S MAIDEN NAME — FIRST: EMMA — MIDDLE — LAST: MATTES
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
(IF YES, GIVE WAR OR DATES): -
16b. SOCIAL SECURITY NO: 273-05-2511
17. INFORMANT: ED GANOCZY — ADDRESS: 9079 WILD APPLE CT. COLUMBIA, MD. 21045

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b): Gastric CA metastatic to liver
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
Chronic anemia, Hepatic encephalopathy

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from Oct 19 88 to Dec 19 88, that (I) (we) last saw the deceased alive on Dec 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Jan Mundl — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/15/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT)
22e. ADDRESS: 10806 Hickory Ridge Rd Columbia

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: 16 DEC 88
23c. NAME OF CEMETERY OR CREMATORY: BROOKLYN HEIGHTS CEM.
23d. LOCATION — CITY OR TOWN: CLEVELAND — COUNTY: CUYAHOGA — STATE: OHIO
24. FUNERAL DIRECTOR NAME: John Dallas Slack — ADDRESS: SLACK FUNERAL HOME ELLICOTT CITY, MD. 21043
25a. DATE REC'D BY REGISTRAR: DEC 16 '88
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 2

DHMH - 1650M 1/81 (VRA 15, 4)

017676 DEC 30 '88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO. 36899

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please register the certificate with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR | |
| HAROLD | JESSE | HORN | 12-25-88 | 2 53 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
| Male | White | 10 29 21 | 67 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | U.S.A. | | Howard County MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Columbia | Howard Cty General | Mold Maker | Glass Products | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Howard | Elkridge | YES [ ] NO [X] | 220 Paul Martin Dr. 21227 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Jesse | | Horn | Jennie | E. | Fryer |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| YES | WW II | 220-05-8282 | Dorothy A. Horn | 220 Paul Martin Dr. 21227 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiorespiratory arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Cancer, lung

DUE TO, OR AS A CONSEQUENCE OF (c) Chronic heart disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Willis Schwaznau | ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 12/26/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| | Howard County General Hosp. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12/29/88 | Cedar Hill Cemetery | Brooklyn Pk. A.A. Maryland |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | DEC 28 1988 | |

016653 DEC 19 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 36900

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| ANGELA | M. | HUNT | 12 06 88 | 4:30 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | White | 03 20 1898 | 90 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | HOWARD COUNTY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| COLUMBIA | HOWARD COUNTY GENERAL HOSPITAL | HOMEMAKER | HOME |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MARYLAND | HOWARD | COLUMBIA | YES ☐ NO ☒ | 6009 MAJORS LANE COLUMBIA, MD 21045 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| AARON | | MAY | MARY | C. | STRUB |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| NO | - | 214-07-4204 | MARY B. MIDDLETON-ADDRESS SAME AS #13 ABOVE. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiac Arrest | Simultan. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Coronary Artery disease | years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (~~this hospital~~) attended the deceased from 11/01, 19 88, to 12/06, 19 88, that (I) (~~we~~) last saw the deceased alive on 11/01 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
|---|---|---|---|
| B.H. Mirchew | M.D. | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/6/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| B.H. Mirchew | 2850 N.RIDGE ROAD-ELLICOTT CITY, MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 12/9/88 | SUNSET MEMORIAL PARK | CUMBERLAND-ALLEGANY-MARYLAND |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET-CUMBERLAND, MARYLAND 21502 | DEC 07 1988 | Gina Davidson-Mondello |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 6

DHMH - 1650M 1/81 (VRA 15, 4)

018297 JAN 1-89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO 36901

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: BERNADINE | MIDDLE: F. | LAST: HURDLE | 2a. DATE OF DEATH MONTH DAY YEAR: 12 28 88 | 2b. HOUR: 7:10 AM | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Jan. 25, 1915 | 6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: Maryland | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County MD. | | |
| 10. CITY OR TOWN OF DEATH: Columbia | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard County General Hosp. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Nurse | 12b. KIND OF BUSINESS OR INDUSTRY: U.S. Public Health | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Howard | 13c. CITY OR TOWN: Jessup | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS / ZIP CODE: 8319 Washington Boulevard #2 20794 | |
| 14. FATHER'S NAME FIRST: Francis | MIDDLE | LAST: Winkler | 15. MOTHER'S MAIDEN NAME FIRST: Dorthea | MIDDLE: M. | LAST: Honneman |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 217-03-5506 | 17. INFORMANT: Francis E. Winkler | ADDRESS: 3102 Keswick Rd. Baltimore, Md. | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Respiratory Failure | 10 hours |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Pulmonary Edema | 10 hours. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Aortic Stenosis | months |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/27 19 88 to 12/28 19 88 that (I) (we) last saw the deceased alive on 12/27 19 88 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: Charles E. Sheeha | DEGREE: M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12/28/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Charles E. Sheeha M.D. | 22e. ADDRESS: 11055 Little Patuxent Pkwy., Columbia Md. | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation | 23b. DATE: 1/2/1989 | 23c. NAME OF CEMETERY OR CREMATORY: Westview Mem. Pk. | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Baltimore, Maryland |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: Olin L. Molesworth, P.A., Damascus, Md. | 25a. DATE REC'D. BY REGISTRAR: JAN 3 1989 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

BP_____

DHMH - 16 60M 7/84 (VRA 15. 4)

017883 DEC -3 89

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6 3 7 6 9 0 3

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST |
|---|---|---|
| Michael | James | Kreckel |

| 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH | DAY | YEAR | 2b. HOUR |
|---|---|---|---|
| 12 | 27 | 19 88 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH | DAY | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | JAN. | 20, | 1968 | 20 YRS. | | | | |

| 2c. DATE PRONOUNCED DEAD MONTH | DAY | YEAR | 2d. HOUR |
|---|---|---|---|
| 12 | 27 | 19 88 | 8:40 AM |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [ ] NEVER MARRIED [XX] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| W. GERMANY | U.S.A. | | Howard County MD |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Columbia | driveway-6717 Allview Dr. | IRON WORKER | CONSTRUCTION |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MARYLAND | HOWARD | COLUMBIA | YES [ ] NO XX | 9930 DELWOOD AVENUE 21046 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| JAMES | P. | KRECKEL | GAIL | | FRAISER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 212-98-9737 | JAMES P. KRECKEL | 9930 DELWOOD AVENUE COLUMBIA, MD. 21046 |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multiple injuries

8150

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | 1:15 XX 12-27- 19 88 | Driver of auto/fixed object impact. |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | road | 6717 Allview Dr., | Columbia, | Howard | MD |

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE _____ TITLE (SPECIFY) Acting Deputy Chief M.D. _____ MEDICAL EXAMINER DATE SIGNED 12-27-88

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn St., Balto., MD 21201

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| BURIAL | 12/30/88 | FORT LINCOLN | BRENTWOOD | | MARYLAND |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A. | 5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045 | DEC 28 1988 | Julia Davidson-Randall |

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

017360 DEC 1988

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF D

REG. 3690 3

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH ESTIMATED XX MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Jacob | Jay | Lehenky | 11-9-88 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| M | White | 05 13 1928 | 60 YRS. | | | 11-16-88 | 5:30P M |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| PENNSYLVANIA | U.S.A. | | Howard County MD |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Ellicott City | 9082 Town & Country Blvd. | GUARD | House of Corr. |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD. | HOWARD | ELLICOTT CITY | YES ☐ NO ☒ | 9082 Town + Country Blvd 21043 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| KUZMA | | LEHENKY | ELIZAB | | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| YES | WWII | 202-20-7563 | CASIMIR LEHENKY | BOX 174 RD5 COATESVILLE PA 19320 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES XX Partial NO ☐ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 11-17-88

EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| BURIAL | 22 NOV 88 | INDIANTOWN GAP NAT'L CEM. | ANNVILLE | LEBANON | PA |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| SLACK FUNERAL HOME | ELLICOTT CITY, MD. 21043 | NOV 29 1988 | [signature] |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE PORTION OF THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DHMH 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

017902 DEC-88 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO. 369041

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Lillian | Evangeline | Noll | 12-26-88 | 7:30 P.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN. |
|---|---|---|---|---|---|
| Female | White | 01 - 21 -1900 | 88 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | Howard County MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Columbia | Howard County General Hospital | Postmistress | Federal Gov't. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Howard | Woodstock | YES ☒ NO ☐ | 1970 Woodstock Road 21163 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| George | A. | Humphrey | Ida | | Widerman |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | ---- | 214-22-0954 | Shirley Merkle | Woodstock, MD 21163 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bradycardia

DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Pulmonary Aspiration

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 12/26, 19 88, to 12/26, 19 88, that (I) (we) last saw the deceased alive on ____, 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED 12/26/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAURER

22e. ADDRESS 2850 North Ridge Rd. Ellicott City MD 21043

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | 12-30-88 | St. John's Cemetery | Ellicott City | Howard | MD |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| HAIGHT FUNERAL HOME | Sykesville, MD | DEC 28 1988 | Linda Davidson-Kendall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, Item 18 should show any injury, or other traumatic event, the medical examiner must be notified promptly.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

017199 DEC 27 88

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG. NO. 36905

1. DECEASED NAME (TYPE OR PRINT): FIRST Susan; MIDDLE Leigh; LAST Pruitt

2a. DATE OF DEATH: KNOWN XX / ESTIMATED ☐ — MONTH 12 DAY 12 YEAR 19 88

2b. HOUR: M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH 10 DAY 17 YEAR 55

6. AGE (IN YEARS LAST BIRTHDAY): 33 YRS.

IF UNDER 1 YR. MONTHS: DAYS: IF UNDER 24 HRS. HOURS: MIN:

2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 12 YEAR 19 88

2d. HOUR: 12:00 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Baltimore, Md.

7b. CITIZEN OF WHAT COUNTRY? United States

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County MD.

10. CITY OR TOWN OF DEATH: columbia

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard County General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: private

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Burtonsville

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 15212 Birmingham Dr. 20866

14. FATHER'S NAME: FIRST James; MIDDLE Alton; LAST Travis

15. MOTHER'S MAIDEN NAME: FIRST Eleanor; MIDDLE Margaret; LAST Meehan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 218-66-9974

17. INFORMANT ADDRESS: Eleanor Benson (mother) same as #13.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Narcotic Intoxication

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY: HOUR A.M. P.M. 10:00AM MONTH 12 DAY 12 YEAR 19 88

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Subject used drugs

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): home

21f. LOCATION: STREET 8371 Columbia Road, CITY OR TOWN Laurel, COUNTY Howard County, STATE MD

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner XX

ACTUAL SIGNATURE: Marjorie Bothwell for

TITLE (SPECIFY): Acting Deputy Chief MEDICAL EXAMINER

DATE SIGNED: 12-13-88

EXAMINER'S NAME (TYPE OR PRINT): Charles P. KOkes, M.D.

ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 12-15-1988

23c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery

23d. LOCATION: CITY OR TOWN Baltimore, COUNTY Baltimore, STATE Md.

24. FUNERAL DIRECTOR: Donald Borgwardt

ADDRESS: 4400 Powder Mill Road, Beltsville, Md. 20705

25a. DATE RECD. BY REGISTRAR: DEC 22 1988

25b. REGISTRAR'S SIGNATURE: Davidson Rondeau

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

017693 DEC 30 68

FOR 1 - STATE REGISTRAR — Item #16b 03-02-89 Per F.H. Film # G649

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 88 036906

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the [illegible] be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (Maiden) — FIRST: Edith — MIDDLE: L. — LAST: Schuhart

2a. DATE OF DEATH — MONTH DAY YEAR: December 26, 1988

2b. HOUR: M

3. SEX: Female

4. RACE: white

5. DATE OF BIRTH — DAY YEAR: 11/04/08

6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Howard MD.

10. CITY OR TOWN OF DEATH: Ellicott City

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Bon Secours

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Self

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md — 13b. COUNTY: Baltimore — 13c. CITY OR TOWN: Arbutus — 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e. STREET ADDRESS: 1259 Greystone Road 21227

14. FATHER'S NAME — FIRST MIDDLE LAST: Theadore Logan

15. MOTHER'S MAIDEN NAME — FIRST MIDDLE LAST: Leonora Hurd

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no — (IF YES, GIVE WAR OR DATES): ———

16b. SOCIAL SECURITY NO.: 214-24-2832A

17. INFORMANT — ADDRESS: L. Ruth McClelland 2114 Fernglen Way

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Lymphoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 mo.
DUE TO, OR AS A CONSEQUENCE OF
(b): 
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse lost
DUE TO, OR AS A CONSEQUENCE OF
(c): 

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Alzheimers Disease

19a. DATE OF OPERATION: —

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from 9-5 19 88 to 12-26 19 88, that (I) (~~he~~) last saw the deceased alive on 11-22 19 88, and that in (my) (~~his~~) opinion death occurred on the date and hour and from the couses stated above, (I) (~~he~~) (did) (did not) view the body after death.

22b. SIGNATURE: David R. Moseman — DEGREE: M.D. — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12-28-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): David R. Moseman, M.D.

22e. ADDRESS: 5205 East Drive, Arbutus, Maryland 21227

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 12/29/88

23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery

23d. LOCATION — CITY OR TOWN COUNTY STATE: Baltimore City, Maryland

24. FUNERAL DIRECTOR — NAME ADDRESS: AMBROSE FUNERAL HOME 1328 SULPHUR SPRING ROAD

25a. DATE REC'D. BY REGISTRAR: DEC 28 1988

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

5

016198 DEC

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 369 07

FOR STATE REGISTRAR AGNES C. SCHUPP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

| | |
|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST Agnes MIDDLE C. LAST Schupp |
| 2a. DATE OF DEATH | MONTH 12/8/88 DAY 12 YEAR 8 88 |
| 2b. HOUR | 1202PM |
| 3. SEX | Female |
| 4. RACE | White |
| 5. DATE OF BIRTH | MONTH 03 DAY 21 YEAR 15 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 73 YRS. |
| IF UNDER 1 YEAR | MONTHS / DAYS |
| IF UNDER 24 HRS. | HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | KENTUCKY |
| 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. |
| 8. | MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Howard COUNTY MD. |
| 10. CITY OR TOWN OF DEATH | Columbia |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Howard County Gen Hosp. |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | HOUSEWIFE |
| 12b. KIND OF BUSINESS OR INDUSTRY | OWN HOME |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | MD. |
| 13b. COUNTY | Howard. |
| 13c. CITY OR TOWN | Ellicott City |
| 13d. INSIDE CITY LIMITS? | YES ☐ NO ☒ |
| 13e. STREET ADDRESS | 3209 SAFARI Court 21043 |
| 14. FATHER'S NAME | FIRST AUSTIN MIDDLE EUGENE LAST POPHAM |
| 15. MOTHER'S MAIDEN NAME | FIRST MARY MIDDLE L. LAST O'BRYAN |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | NO |
| 16b. (IF YES, GIVE WAR OR DATES) | ---------- |
| 16b. SOCIAL SECURITY NO. | 404-90-7442 |
| 17. INFORMANT | PATRICIA LEAHY |
| ADDRESS | 3209 SAFARI CT. ELLICOTT CITY MD. 21043 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: approx. 2 hours

DUE TO, OR AS A CONSEQUENCE OF

(b) Congestive heart failure, renal failure, ischemic cardiac disease — years

DUE TO, OR AS A CONSEQUENCE OF

(c) atherosclerotic vascular + renal disease — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from over the past several years to 12/8 19 88 (that (I) (we) last saw the deceased alive on 12/8 19 88, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Stephen A Valenti MD — DEGREE Consultant — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 12/8/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen A Valenti MD — 22e. ADDRESS Howard County General Hospital

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY / STATE |
| BURIAL | 12/12/88 | RESTHAVEN CEMETERY | LOUISVILLE | KENTUCKY |

24. FUNERAL DIRECTOR NAME AND ADDRESS: LEROY M. & RUSSELL C. WITZKE FUNERAL HOME 5555 TWIN KNOLLS RD. COLUMBIA, MD. 21045

25a. DATE REC'D. BY REGISTRAR: DEC 13 1988

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landrum

016399 DEC 1588

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO 88 036908

1. DECEASED NAME (TYPE OR PRINT) — FIRST: John — MIDDLE: F — LAST: Sinn

2a. DATE OF DEATH — MONTH: 12 — DAY: 9 — YEAR: 88

2b. HOUR: 4:20 AM

3. SEX: M

4. RACE: W

5. DATE OF BIRTH — MONTH: 01 — DAY: 27 — YEAR: 07

6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): US MD

7b. CITIZEN OF WHAT COUNTRY? US

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County MD

10. CITY OR TOWN OF DEATH: Columbia

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HCGH

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RET. STEAMSHIP

12b. KIND OF BUSINESS OR INDUSTRY: AGENT

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: HOWARD

13c. CITY OR TOWN: SYKESVILLE

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS / ZIP CODE: 825 Misty Meadow 21784

14. FATHER'S NAME — FIRST: WILLIAM — MIDDLE: REXFORD — LAST:

15. MOTHER'S MAIDEN NAME — FIRST: FRANCES — MIDDLE: MEYERS — LAST:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 705-10-7505

17. INFORMANT ADDRESS: Violet Sinn-825 Misty Meadow Sykesville, Md. 21784

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): intra cranial hemorrhage in (L) basal ganglia

DUE TO, OR AS A CONSEQUENCE OF (b): atherosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c): hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 18 hr.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): hypercholesterolemia, gout

19a. DATE OF OPERATION: —

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [X]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2): —

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.): —

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE: —

22a. I certify that (I) (this hospital) attended the deceased from 12/8 19 88 to 12/9 19 88 that (I) (we) last saw the deceased alive on 12/9 19 88 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Patrick A. Tolcinds MD — DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 12/9/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): PATRICK A. TOLCINDS

22e. ADDRESS: 10772 HICKORY RIDGE ROAD COLUMBIA, MD 21044.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal

23b. DATE: 12-9-88

23c. NAME OF CEMETERY OR CREMATORY: —

23d. LOCATION — CITY OR TOWN — COUNTY — STATE: —

24. FUNERAL DIRECTOR — NAME: State Anatomy Board — ADDRESS: Balto., Md.

25a. DATE REC'D. BY REGISTRAR: DEC 14 1988

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

0166 16 DEC 19 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36900
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH | DAY | YEAR / 2b. HOUR |
| HUBERT | A. | SLATER | 12 | 08 | 88 / 6:40 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH | DAY | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|---|---|
| Male | White | 02 | 22 | 97 | 91 YRS. | | | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Mass. | U. S. A. | | Howard Co. MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Columbia | Howard Co. General Hosp. | Graffic Art Teacher-Prov.R.I. | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Md | Howard | Columbia | YES ☐ NO ☒ xx | 5066 Durham Rd. West 21044 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Rothwell | | Slater | Ada | | ? |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| Yes | | 035124084 | 5066 Durham Rd. West - Columbia, Md. #21044 Mrs. Barbara Frank |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) congestive heart failure

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Renal failure, sepsis

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| N/A | | YES ☐ NO ☑ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 12/3, 19 88, to 12/8, 19 88, that (I) (we) last saw the deceased alive on 12/7, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Lynn D. Alonso | M.D. | ATTENDING PHYSICIAN ☐ | MEDICAL DIRECTOR ☑ | STAFF PHYSICIAN ☐ | 12-8-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| LYNN D. ALONSO | COLUMBIA-FREESTATE TWO KNOLL NORTH DR., COLUMBIA, MD 21045 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | Dec. 13, 1988 | Highland Mem. Pk. Cemetery | Johnston, | | Rhode Island |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| G. TRUMAN SCHWAB | 3512 FREDERICK AVE. BALTO. MD 21229 | DEC 16 1988 | Julia Davidson-Rendeer |

17791 DEC 30 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO. 36910

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT): FIRST Claoma; MIDDLE E.; LAST Suhrie
2a. DATE OF DEATH: MONTH DAY YEAR: December 24, 1988
2b. HOUR: 6:00 A M
3. SEX: Female
4. RACE: white
5. DATE OF BIRTH: MONTH DAY YEAR: December 14, 1905
6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS; IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Kansas
7b. CITIZEN OF WHAT COUNTRY?: United States
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County MD.
10. CITY OR TOWN OF DEATH: Woodbine
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Tara Retirement Center
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker
12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Frederick
13c. CITY OR TOWN: Frederick
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS / ZIP CODE: 7427 Round Hill Road / 21701

14. FATHER'S NAME: FIRST Benjamin; MIDDLE E.; LAST Miller
15. MOTHER'S MAIDEN NAME: FIRST Anna; MIDDLE; LAST Meyer
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 135-38-0339
17. INFORMANT: Claoma E. Fearing, Same as 13 — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 minute
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from October 1, 1987 to December 24, 1988 that (I) (we) last saw the deceased alive on May 31, 1988 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: Covering for Dr. Johnson — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒
22c. DATE SIGNED: 12/25/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Christopher Omford
22e. ADDRESS: 615 West Montgomery Ave. Rockville MD 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 12-27-88
23c. NAME OF CEMETERY OR CREMATORY: Douglas Cemetery
23d. LOCATION: CITY OR TOWN Troutdale; COUNTY Oregon; STATE

24. FUNERAL DIRECTOR NAME AND ADDRESS: Bateman-Carroll Funeral Home, 520 West Powell Blvd., Gresham, OR 97030
25a. DATE REC'D. BY REGISTRAR: DEC 28 1988
25b. REGISTRAR'S SIGNATURE

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death in the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

018069 JAN 4 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 36911

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: AUGUST | MIDDLE: U | LAST: SUNELL | 2a. DATE OF DEATH MONTH: 12 DAY: 22 YEAR: 88 | 2b. HOUR: 0336 A M | |
| 3. SEX: MALE | 4. RACE: CAUCASIAN | 5. DATE OF BIRTH MONTH: 07 DAY: 25 YEAR: 17 | 6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS | IF UNDER 1 YEAR MONTHS: DAYS: | IF UNDER 24 HRS. HOURS: MIN.: |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MINNASOTA | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD COUNTY, MD. | | |
| 10. CITY OR TOWN OF DEATH: Columbia | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOWARD COUNTY GENERAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED IRON WORKER | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD. | 13b. COUNTY: Howard | 13c. CITY OR TOWN: Ellicott City | 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] | 13e. STREET ADDRESS: 8643 Old Frederick Rd 21043 | |
| 14. FATHER'S NAME FIRST: JOHN MIDDLE: SUNELL LAST: | 15. MOTHER'S MAIDEN NAME FIRST: HELEN MIDDLE: LAST: | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 220-09-3740 | 17. INFORMANT: WILLIAM E. SUNELL | ADDRESS: 8643 OLD FREDERICK Rd. | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SHOCK

DUE TO, OR AS A CONSEQUENCE OF

(b): Congestive Heart Failure. — MONTHS

DUE TO, OR AS A CONSEQUENCE OF

(c): Coronary artery disease — MONTHS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Diabetes mellitus

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from Dec 19 87 to 12-22 19 88, that (I) (we) last saw the deceased alive on 12-17 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Jerry I. Levine | DEGREE: MD — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED: 12-22-88 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): JERRY I. LEVINE, M.D. | 22e. ADDRESS: 11055 LITTLE PATUXENT PKWY COLUMBIA, MD. 21044 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: DEC 24 88 | 23c. NAME OF CEMETERY OR CREMATORY: LAKEVIEW | 23d. LOCATION CITY OR TOWN: / COUNTY: CARROLL CO. / STATE: MD. | |
| 24. FUNERAL DIRECTOR NAME: HARRY H. WITTE ADDRESS: ELLICOTT CITY | 25a. DATE RECD BY REGISTRAR: DEC 23 88 | 25b. REGISTRAR'S SIGNATURE: Jane Harrison-Kimball | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 4. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal from the state.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other trauma, the medical examiner must be notified.

BP 4

DHMH - 16 50M 1/81 (VRA 15, 4)

No

John Shelly

Howard

U.S.

15610 DEC -7 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO 3 9 1 2

1. DECEASED NAME (TYPE OR PRINT): GERALD N. THOMAS

2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ — 12 03 1988 — 2b. HOUR 2:12 PM

3. SEX: MALE — 4. RACE: CAUC — 5. DATE OF BIRTH: 03 31 32 — 6. AGE (IN YEARS LAST BIRTHDAY): 56 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: 12/03 1988 — 2d. HOUR 2:12 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County MD

10. CITY OR TOWN OF DEATH: Columbia — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard County Gen Hosp. — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Truck Driver — 12b. KIND OF BUSINESS OR INDUSTRY: Retired

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD. — 13b. COUNTY: Anne Arundel — 13c. CITY OR TOWN: Glen Burnie — 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e. STREET ADDRESS: 415 3rd Avenue 21061

14. FATHER'S NAME: Harry N. Thomas — 15. MOTHER'S MAIDEN NAME: Theresa Miller

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes XX — (IF YES, GIVE WAR OR DATES): Korea — 16b. SOCIAL SECURITY NO.: 213-28-7284 — 17. INFORMANT ADDRESS: Mary Ann Thomas, same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIORESPIRATORY ARREST
Conditions, if ony, which gave rise to immediate couse (a) stating the underlying couse lost.
DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD, Hypertension, R/O Pulmonary Embolus
DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Bert F Morton — TITLE (SPECIFY): M.D. DEPUTY MEDICAL EXAMINER — DATE SIGNED: 12/3/88

EXAMINER'S NAME (TYPE OR PRINT): BERT F. MORTON — ADDRESS: 2802 MONTCLAIR DRIVE, E.C. 21042

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 6 Dec. 88 — 23c. NAME OF CEMETERY OR CREMATORY: Crownsville MD Vet. Cem. — 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Crownsville, A.A., MD

24. FUNERAL DIRECTOR NAME: James S. Kirkley, Glen Burnie, MD 21061 — ADDRESS: 421 Crain Hwy. S.E.

25a. DATE REC'D. BY REGISTRAR: DEC 06 1988 — 25b. REGISTRAR'S SIGNATURE: Julia Tindon-Landers

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED (WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

016601 DEC 19 88

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO. 369133

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Roger | Middle: MELVIN | Last: THOMAS, SR. | 2a. DATE OF DEATH Month/Day/Year: 12-15-88 | | 2b. HOUR: 4AM |
| 3. SEX: MALE | RACE: BLACK | 5. DATE OF BIRTH Month/Day/Year: 3/21/1915 | 6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD COUNTY, MD. | | |
| 10. CITY OR TOWN OF DEATH: JESSUP | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOWARD CO. GENERAL HOSP. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CUSTODIAN | 12b. KIND OF BUSINESS OR INDUSTRY: NURSING HOME | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MARYLAND | HOWARD | JESSUP, MARYLAND | YES [ ] NO [X] | 9929 GUILFORD RD. 20794 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last |
|---|---|
| DANIEL / THOMAS | IDELLA / ALLEN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 219-12-5924 | MRS. MARJORIE L. THOMAS | JESSUP, MARYLAND 9929 GUILFORD RD. 20794 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinoma of Prostate — Approximate interval between onset and death: 3 yrs.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 11-29, 19 88, to 12-15, 19 88, that (I) (we) last saw the deceased alive on 12-14, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Richard V. Smith MD. | ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 12-15-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Richard V. Smith, M.D. | 10802 Hickory Ridge Rd Columbia Md. 21044 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 12/19/1988 | MD. NATIONAL MEM. PK | LAUREL, MARYLAND |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| NUTTER FUNERAL HOMES, INC, 2501 GWYNNS FALLS PKWY, BALTO. MD. 21216 | DEC 15 1988 | Julia Dickson Rendara |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

P

BP

DHMH - 1650M 1/81 (VRA 15, 4)

017482 DEC 28 88

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 369114

ADA VIVIAN TUMA

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| ADA | VIVIAN | TUMA | 12/16/88 | 12-16-88 6:10 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 11 14 93 | 95 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | HOWARD COUNTY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| COLUMBIA | HOWARD COUNTY GENERAL HOSPITAL | HOUSEWIFE | OWN HOME |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MARYLAND | HOWARD | COLUMBIA | YES ☐ NO ☒ | 10702 CORDAGE WALK 21044 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| JAVAS | THOMAS | ABBOTT | ALICE | | FALES |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | IF YES, GIVE WAR OR DATES | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 219-22-0493 | RONALD BOSWELL | COLUMBIA, MD 10702 CORDAGE WALK 21044 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Respiratory Failure | Seconds |
| DUE TO, OR AS A CONSEQUENCE OF (b) | SEPSIS | Days |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Acute RENAL Failure | Days |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 12-14 19 88 to 12-16 19 88, that (I) (we) last saw the deceased alive on 12-16 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| [signature] | MD | 12-16-88 |

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| JERRY I. LEVINE, M.D. | 11055 Little Patuxent Pky, Columbia, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| CREMATION | 12/17/88 | WESTVIEW CREMATORY | WESTVIEW | | MARYLAND |

| 24. FUNERAL DIRECTOR (NAME) & (ADDRESS) | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| LEROY M & RUSSELL C WITZKE FUNERAL HOME 5555 TWIN KNOLLS ROAD COLUMBIA, MD 21045 | DEC 21 1988 | Julia Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

16868 DEC

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 369 15

1. DECEASED NAME (TYPE OR PRINT): First Eva Middle Mae Last Vollstedt

2a. DATE OF DEATH: Month 12 Day 15 Year 88

2b. HOUR: 10:50 P.M.

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH: Month 7 Day 27 Year 38

6. AGE (IN YEARS LAST BIRTHDAY): 50 YRS. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County, Md MD.

10. CITY OR TOWN OF DEATH: Columbia

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard County General Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Adm. Assistant

12b. KIND OF BUSINESS OR INDUSTRY: Research

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Howard

13c. CITY OR TOWN: Clarksville

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS: 7162 Route #32 21029

14. FATHER'S NAME: First Lawrence Middle K. Last Griffin Sr.

15. MOTHER'S MAIDEN NAME: First Eva Middle B. Last Keyser

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 213-34-1970

17. INFORMANT'S ADDRESS: Clarksville, Maryland 21029

INFORMANT: James E. Vollstedt 7162 Route #32

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory failure — Approximate interval between onset and death: Days

DUE TO, OR AS A CONSEQUENCE OF

(b): Metastatic small cell carcinoma of Lung — Months

DUE TO, OR AS A CONSEQUENCE OF

(c): Renal failure Acute — Acute.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH [ ] (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-5 19 88 to 12-15 19 88, that (I) (we) last saw the deceased alive on 12-15-88 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE: MD. ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 12/16/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Jerry L. Lehrer, M.D.

22e. ADDRESS: 11055 Little Patuxent Pkwy, Col., Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 12/19/88

23c. NAME OF CEMETERY OR CREMATORY: Maryland Veterans

23d. LOCATION: CITY OR TOWN: Crownsville COUNTY: A.A. STATE: MD.

24. FUNERAL DIRECTOR: NAME AND ADDRESS: RAYMOND C. FINK GLEN BURNIE, MD. 21061

25a. DATE REC'D. BY REGISTRAR: DEC 19 1988

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 036916

017045 DEC 22 88

1. DECEASED NAME (TYPE OR PRINT): FIRST DONALD MIDDLE L. LAST WEBB
2a. DATE OF DEATH: MONTH 12 DAY 10 YEAR 88
2b. HOUR: 7:44 PM
3. SEX: male
4. RACE: W
5. DATE OF BIRTH: MONTH 10 DAY 16 YEAR 23
6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD
7b. CITIZEN OF WHAT COUNTRY?: U.S.A
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County MD.
10. CITY OR TOWN OF DEATH: Columbia md.
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard County General Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):
12b. KIND OF BUSINESS OR INDUSTRY: AGENT INSURANCE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: HOWARD
13c. CITY OR TOWN: ELLICOTT CITY
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS / ZIP CODE: 8485 LINWOOD DR. 21043

14. FATHER'S NAME: FIRST THOMAS MIDDLE LAST WEBB
15. MOTHER'S MAIDEN NAME: FIRST LOUISE MIDDLE J LAST RETHER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES
16b. (IF YES, GIVE WAR OR DATES): W.W. II
16b. SOCIAL SECURITY NO.: 213-28-2724
17. INFORMANT: ANTOINETTE WEBB ADDRESS: 8485 LINWOOD DR. 21043 ELLICOTT CITY

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minute
DUE TO, OR AS A CONSEQUENCE OF (b): Encephalopathy — days
DUE TO, OR AS A CONSEQUENCE OF (c): Brain Tumor — week
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Paul D. Olivo DEGREE: MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]
22c. DATE SIGNED: 12/10/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): OLIVO PAUL D.
22e. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: 12-14-88
23c. NAME OF CEMETERY OR CREMATORY: PARKWOOD
23d. LOCATION CITY OR TOWN: BALTIMORE COUNTY STATE: MD.
24. FUNERAL DIRECTOR NAME: HARRY H. WITZKE INC. ADDRESS: 4112 COLUMBIA RD. 21043 ELLICOTT CITY MD
25a. DATE REC'D BY REGISTRAR: DEC 12 '88
25b. REGISTRAR'S SIGNATURE: Barbara Anderson-Randall

BP 10

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

0166 12 DEC 19 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

58 3691 7
REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Edwina | MIDDLE: L | LAST: Weitzel | 2a. DATE OF DEATH MONTH DAY YEAR: 12-13-88 | 2b. HOUR: 0112 PM | |
| 3. SEX: Female | 4. RACE: Cauc | 5. DATE OF BIRTH MONTH DAY YEAR: 7 8 10 | 6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD Co. MD | | |
| 10. CITY OR TOWN OF DEATH: Columbia | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard County General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired-Lloyd E. | 12b. KIND OF BUSINESS OR INDUSTRY: Mitchell | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD | 13b. COUNTY: Baltimore | 13c. CITY OR TOWN: Woodlawn | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13a. STREET ADDRESS: 22 Gwynn Lake Dr. | 21207 |
| 14. FATHER'S NAME FIRST: William | MIDDLE: Edward | LAST: Weaver | 15. MOTHER'S MAIDEN NAME FIRST: Edwina | MIDDLE: | LAST: MIller |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): -- | 16b. SOCIAL SECURITY NO.: 213-01-1655A | 17. INFORMANT: Luanne S. Summers | ADDRESS: Baltimore MD 21207 22 Gwynn Lake Dr. | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be planned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): RESPIRATORY FAILURE — 2 DAYS
DUE TO, OR AS A CONSEQUENCE OF (b): CARCINOMA OF LIVER — 3 MOS.
DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: 12/5/88 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: CA OF LIVER | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Rene L Gelber | DEGREE: MD | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): RENE' L. GELBER | 22e. ADDRESS | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation | 23b. DATE: 12-15-88 | 23c. NAME OF CEMETERY OR CREMATORY: Westview Crematory | 23d. LOCATION CITY OR TOWN: Catonsville COUNTY: Baltimore STATE: MD | |
| 24. FUNERAL DIRECTOR NAME: Loring Byers Funeral DIrectors, Inc ADDRESS: 8728 Liberty Rd. Randallstown, MD 21133 | 25a. DATE REC'D BY REGISTRAR: DEC 16 1988 | 25b. REGISTRAR'S SIGNATURE | | |

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

016478 DEC 16 88

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36913
REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| FRANK | E. | WHITT | DECEMBER 13,1988 | 10 30 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | NOVEMBER 13, 1910 | 78 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED XX | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| WEST VIRGINIA | U.S.A. | | HOWARD COUNTY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| ELLICOTT CITY | 3512 N. CHATHAM ROAD | CONSTRUCTION - SHEET METAL WORKER | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒XX | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MARYLAND | HOWARD | ELLICOTT CITY | | 3512 N. CHATHAM ROAD 21043 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| ISIAH | | WHITT | HULDA | | MULLINS |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | ------ | 236-05-8525 | FREDA GOUGH | 3512 N. CHATHAM ROAD ELLICOTT CITY, MD. 21043 |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a) Gangrene of foot — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 mos

DUE TO, OR AS A CONSEQUENCE OF (b) Peripheral vascular dis

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
D.M. - NIDD

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 11-88, 19__, to 12-13-88, 19__, that (I) (we) last saw the deceased alive on 12-13-88, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|---|
| | MD | | 12-14-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| JOSE APTER M.D. | 5400 OLD COURT ROAD SUITE 103 RANDALLSTOWN, MARYLAND 21133 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 12/16/88 | WOODLAWN | WOODLAWN MARYLAND |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A. 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | DEC 15 1988 | Julia Dorsey Lindsay |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81
(VRA 15, 4)

0 1 7 2 3 7 DEC 27 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

88 36919 REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Nellie | MIDDLE: P | LAST: WiebKing | 2a. DATE OF DEATH MONTH: 12 | DAY: 18 | YEAR: 88 |
| 2b. HOUR: 3:15 AM/PM | | | | | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH: 4 DAY: 5 YEAR: 11 | 6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS | IF UNDER 1 YEAR MONTHS: DAYS: | IF UNDER 24 HRS HOURS: MIN.: |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Balto, Md. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Howard MD. | | |
| 10. CITY OR TOWN OF DEATH: Columbia | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard Co. General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Beautician | 12b. KIND OF BUSINESS OR INDUSTRY: Hair dresser | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION): Arnold Md.

| | | | | |
|---|---|---|---|---|
| 13a. STATE: Md. | 13b. COUNTY: A.A. | 13c. CITY OR TOWN: Arnold | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 344 Alameda Pky. 21012 |
| 14. FATHER'S NAME FIRST: Morris | MIDDLE: | LAST: Rokos | 15. MOTHER'S MAIDEN NAME FIRST: Nellie | MIDDLE: LAST: Nover |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no | 16b. (IF YES, GIVE WAR OR DATES) SOCIAL SECURITY NO.: 216-07-0556 | 17. INFORMANT: Nancy L. Wallace | ADDRESS: 344Alameda Pky. 21012 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIORESPIRATORY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF (b): PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF (c): MYELOMA

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CHF

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | |
|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: I. H. Desombry | DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ | 22c. DATE SIGNED: 12-18-88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): I. H. DESOMBRY | 22e. ADDRESS: 10792 HICKORY RIDGE RD COLUMBIA | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12-28-88 | 23c. NAME OF CEMETERY OR CREMATORY: Meadowridge Pk. | 23d. LOCATION CITY OR TOWN: Howard County COUNTY: STATE: MD 21044 | |
| 24. FUNERAL DIRECTOR NAME: Sterling Ashton F.H. ADDRESS: 736 Edmondson Ave. Catonsville | 25a. DATE REC'D. BY REGISTRAR: DEC 21 1988 | 25b. REGISTRAR'S SIGNATURE: Marion Kendall | | |

18170 JAN -5 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 88 36920

1. DECEASED NAME (TYPE OR PRINT) — FIRST Marie M. MIDDLE LAST BIRK
2a. DATE OF DEATH — MONTH December DAY 16 YEAR 1988
2b. HOUR 12:34 A.M.
3. SEX: Female
4. RACE: white
5. DATE OF BIRTH — MONTH October DAY 18 YEAR 1899
6. AGE (IN YEARS LAST BIRTHDAY) 89 Yrs. YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Germany
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ xxxxx
9. BALTIMORE CITY OR COUNTY OF DEATH: Kent County MD.
10. CITY OR TOWN OF DEATH: Chestertown
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Magnolia Hall Nursing Center
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Home maker
12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Kent
13c. CITY OR TOWN: Betterton
13d. INSIDE CITY LIMITS? YES XX NO ☐
13e. STREET ADDRESS / ZIP CODE: P.O. Box # 21610

14. FATHER'S NAME — FIRST Jacob MIDDLE LAST Messner
15. MOTHER'S MAIDEN NAME — FIRST Marie MIDDLE LAST Koch
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no — (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 820 05 9202
17. INFORMANT: Richard Story — ADDRESS: 522 Mark Drive Westminister, Md. 21157

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
(b): pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: M
DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/16/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Michael Bienefeld
22e. ADDRESS: Chestertown, Md. 21620

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Dec 19, 1988
23c. NAME OF CEMETERY OR CREMATORY: Still Pond Cemetery
23d. LOCATION — CITY OR TOWN: Still Pond, STATE: Maryland
24. FUNERAL DIRECTOR — NAME: J. Willis Wells — ADDRESS: Chestertown, Md.
25a. DATE REC'D. BY REGISTRAR: DEC 16 '88
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 2 + 3

DHMH - 16 60M 7/84
(VRA 15, 4)

017158 DEC 27 '88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

58 36921
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 6

DHMH - 1650M 1/81 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | GEorge | Dudley | Bostic | 2a. DATE OF DEATH MONTH DAY YEAR | December 12, 1988 6:21 pm |
| 3. SEX | MALE | 4. RACE | White | 5. DATE OF BIRTH MONTH DAY YEAR | 09 12 20 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 68 YRS | IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Sudlersville, Md | 7b. CITIZEN OF WHAT COUNTRY? | USA | 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Kent County MD. | | | | |
| 10. CITY OR TOWN OF DEATH | Chestertown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Kent & Queen Annes Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Farmer / Painter |
| 12b. KIND OF BUSINESS OR INDUSTRY | Self | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | MD | 13b. COUNTY | Kent | 13c. CITY OR TOWN | Chestertown |
| 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | | 13e. STREET ADDRESS | Rt 5 Box 371 | 21620 | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | Stephen | Enoch | Bostic | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | LuLA VIOLA CANNON |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | NO | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | 215-20-2547 |
| 17. INFORMANT | Betty L. Bostic | ADDRESS | Same As Above | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: COPD, H/O Dysrhythmia, TOBACCO ABUSE

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION / | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
| [signature] | MD | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | Donald Applebaum M.D. | 22e. ADDRESS | P.O. Box 667 Chestertown Md 21620 |

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Burial | 23b. DATE | 12-15-88 | 23c. NAME OF CEMETERY OR CREMATORY | Church Hill Cemetery |
| 23d. LOCATION CITY OR TOWN | Church Hill | COUNTY | QA | STATE | MD |
| 24. FUNERAL DIRECTOR NAME | Tom Helfenbein Funeral Home | ADDRESS | Church Hill MD | 25a. DATE REC'D. BY REGISTRAR | DEC 14 '88 |
| 25b. REGISTRAR'S SIGNATURE | Gina Davidson-Randall | | | | |

18172 JAN -5 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 36923

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Fannie | Middle: Ida | Last: Dulin | 2a. DATE OF DEATH Month: 12 Day: 9 Year: 88 | 2b. HOUR 6:33pm M | |
| 3. SEX: Female | 4. RACE: Cauc. | 5. DATE OF BIRTH Month: Sept Day: 15, Year: 1900 | 6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Kent MD. | | |
| 10. CITY OR TOWN OF DEATH: Chestertown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Kent & Queen Annes Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Home | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | Kent | Massey | YES ☐ NO ☒ | General Delivery 21650 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. IF YES, GIVE WAR OR DATES | 16b. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|---|---|---|
| Joseph Edwards | Carrie L. King | N/A | N/A | 218-20-3940 | Carrie Thrift Chestertown, MD |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b): CHF

DUE TO, OR AS A CONSEQUENCE OF (c): ASCVD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Senility, Heart Disease

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 12/7, 19 88, to 12/9, 19 88, that (I) (we) last saw the deceased alive on 12/9, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
|---|---|---|---|
| | MD | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Vohra Chandrakant J MD | PO Box 667 Chestertown Md 21620 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12/13/88 | Massey Cemetery | Massey Kent MD |

| 24. FUNERAL DIRECTOR NAME, ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Gary Fellows, Box 270, Millington, MD 21651 | DEC 16 '88 | Gisha Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 7

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

017316 DEC 20 88

1 - FOR STATE REGISTRAR

REG. NO. 3 5 9 2 1

DECEASED NAME (TYPE OR PRINT): FIRST John; MIDDLE; LAST Johnson

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 12 DAY 17 YEAR 88 — 2b. HOUR M

3. SEX: Male — 4. RACE: BLK — 5. DATE OF BIRTH: MONTH 11 DAY 8 YEAR 22 — 6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 17 YEAR 88 — 2d. HOUR 7:30P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Federalsburg MD — 7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Kent County MD.

10. CITY OR TOWN OF DEATH: GALENA, MD

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Rts. 301 & 290

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Labor — 12b. KIND OF BUSINESS OR INDUSTRY: Constructio

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: DE — 13b. COUNTY: Nwe Castle — 13c. CITY OR TOWN: Wilmington — 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS: 2604 Jessup St. 99999

14. FATHER'S NAME: FIRST John MIDDLE LAST Johnson Sr.

15. MOTHER'S MAIDEN NAME: FIRST Mary MIDDLE LAST Morris

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 221-14-5685

17. INFORMANT ADDRESS: Hattie M. Johson, 2604 Jessup St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple injuries — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
8150

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR XX P.M. MONTH 12 DAY 17 YEAR 88 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): Driver in auto/fixed object impact

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): road — 21f. LOCATION STREET: Rts. 301 & 290 CITY OR TOWN: COUNTY: Kent, STATE: MD

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE: Mario F. Golle Jr — TITLE (SPECIFY): M.D. Assistant MEDICAL EXAMINER — DATE SIGNED 12/18/88

EXAMINER'S NAME (TYPE OR PRINT): Mario F. Golle, Jr, M.D. — ADDRESS: 111 Penn St. Balto.MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 12-24-88 — 23c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery — 23d. LOCATION CITY OR TOWN: Wilmington, COUNTY: New Castle, STATE: DE

24. FUNERAL DIRECTOR NAME: JAMES A. Morton F.H. ADDRESS: 701 LAURENS ST.

25a. DATE REC'D. BY REGISTRAR: DEC 23 1988 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

02/84 25M BP

DHMH - 17 (VR/A18 ME (5))

016916 DEC 21 88

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36925
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) — FIRST | MIDDLE | LAST | 2a. DATE OF DEATH — MONTH | DAY | YEAR | 2b. HOUR |
| Ethel | Elizabeth | Kendall | 12-8-88 | | | 1:20A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH — MONTH | DAY | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR — MONTHS | DAYS | IF UNDER 24 HRS — HOURS | MIN. |
|---|---|---|---|---|---|---|---|---|---|
| Female | White | 4- | 16- | 18 | 70 YRS | | | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| | USA | MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | Kent MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Chestertown | Kent & Queen Anne's Co. Hosp. INC | Laborer | Various |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
|---|---|---|---|---|---|
| Maryland | Kent | Rock Hall | YES ☒ NO ☐ | Sharp Street | 21661 |

| 14. FATHER'S NAME — FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME — FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Raymond | Watson | | Mary | Virginia | Elburn |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | 219 14 4537 | Shirley Vandiver | Leighton, Ala. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Circulatory collapse | minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Histiocytic lymphoma | 6 months |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☑ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION — STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from Jan 19 76 to 12/8 19 88, that (I) (we) last saw the deceased alive on 12/7 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| G Baumann | MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/8/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| C-G BAUMANN | CHESTERTOWN, Md 21620 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION — CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | 12/11/88 | Wesley Chapel Cem. | Rock Hall, | Maryland | |

| 24. FUNERAL DIRECTOR — NAME | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| J Willis Wells | J. Willis Wells, Chestertown, Md. | DEC 09 '88 | Julia Davidson-Randall |

DHMH - 1650M 1/81 (VRA 15, 4)

018258 JAN -6 88

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 369 26 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| James | Edward | Larrimore JR. | December 26, 1988 | 4:16AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| M | W | March 18, 1958 | 30 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| MD | USA | | Kent County MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CHestertown | Kent & Queen Annes Hospital Inc | None | None |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | Wicomico | Salisbury | YES ☒ NO ☐ | Snow Hill (Holly Ctr) 21863 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| James | Edward | Larrimore, Sr. | Jean | Ruth | McNeil |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| N/A | N/A | 214-68-6455 | Jean Ruth McNeil, Crumpton, MD |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) cardiorespiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Superior mesenteric art occlusion

DUE TO, OR AS A CONSEQUENCE OF (c) Torsion of mesenteric artery.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
|---|---|---|---|
| Gerard S O'Connor M.D. | MD | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | 12/26/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Gerard S. O'Connor M.D. | |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12/29/88 | Galena Cemetery | Galena Kent MD |

| 24. FUNERAL DIRECTOR NAME ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Gary Fellows, Box 270, Millington, MD 21651 | DEC 27 '88 | Julia Davidson-Randall |

BP 4

DHMH - 16 50M 1/81 (VRA 15, 4)

016372 DEC 15 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 369 27
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Emma EMMA Middle: May Last: Penn PENN | | | | 2a. DATE OF DEATH Month Day Year: 12/10/88 | 2b. HOUR: 6:40 P M |
| 3. SEX: Female F | 4. RACE: Caucasian W | 5. DATE OF BIRTH Month Day Year: Feb. 13 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS. | If under 1 year: Months / Days; If under 24 hrs: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | | 9. BALTIMORE CITY OR COUNTY OF DEATH: Kent MD. | |
| 10. CITY OR TOWN OF DEATH: Millington | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): RD 1, Box 262 21651 | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Glass Cutter | 12b. KIND OF BUSINESS OR INDUSTRY: Manufact. |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md. | 13b. COUNTY: Baltimore | 13c. CITY OR TOWN: Woodlawn | 13d. INSIDE CITY LIMITS? YES. NO ☒ | 13e. STREET ADDRESS: 6919 Dogwood Rd. 21207 | |
| 14. FATHER'S NAME First: Frederick Middle: H. Last: Schuman | | | | 15. MOTHER'S MAIDEN NAME First: Alverta Middle: B. Last: Hissey | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A | (IF YES, GIVE WAR OR DATES): N/A | 16b. SOCIAL SECURITY NO.: 219-03-6924 | | 17. INFORMANT: Vernon Miller | Box 262 Rd#1 Millington, Md. 21651 ADDRESS |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardio Pulmonary Arrest | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Metastatic Lung CA to Brain | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Lung Carcinoma | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: [signature] | DEGREE: MD | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12/11/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): John C. Arrabal, M.D. | 22e. ADDRESS: Mid Town Mall Chestertown, MD 21620 | | |

Covering for Dr. Wun-pt's Dictn

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12-14-88 | 23c. NAME OF CEMETERY OR CREMATORY: Baltimore National | 23d. LOCATION CITY OR TOWN: Baltimore COUNTY: City STATE: MD | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: MacNabb Funeral Home, Catonsville, MD | 25a. DATE REC'D BY REGISTRAR: DEC 13 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Tenderson-Pendarvis | | |

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

18255 JAN -6 89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 369238 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

BP 11

DHMH - 16 50M 1/81 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | Clarence | Elmer | Prince | 2a. DATE OF DEATH MONTH / DAY / YEAR | 12 / 25 / 88 |
| 2b. HOUR | 5:30 PM | | | | |
| 3. SEX | Male | | | | |
| 4. RACE | White | | | | |
| 5. DATE OF BIRTH MONTH / DAY / YEAR | March 2, 1913 | | | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 75 Yrs YRS | | | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Tennesse | | | | |
| 7b. CITIZEN OF WHAT COUNTRY? | USA | | | | |
| 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | | | | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Kent MD. | | | | |
| 10. CITY OR TOWN OF DEATH | Chestertown | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | The Kent & Queen Annes Hospital, Inc. | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Theatre Owner | | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Maryland | | | | |
| 13b. COUNTY | Queen Anne | | | | |
| 13c. CITY OR TOWN | Chestertown | | | | |
| 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | | | | | |
| 13e. STREET ADDRESS | P.O. Box # 449 (RFD 21620 (Chester Harbor | | | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | Towning | Prince | | | |
| 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Lucille | Hooper | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | Yes | | | | |
| (IF YES, GIVE WAR OR DATES) | WW 2 | | | | |
| 16b. SOCIAL SECURITY NO. | 578 03 7845 | | | | |
| 17. INFORMANT | Catherine Prince | | | | |
| ADDRESS | P.O. Box # 449 Chestertown, Md. 21620 | | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Possible Pulmonary Embolus
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Gerard S. O'Connor MD | DEGREE MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED 12/26/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | Gerard S. O'Connor MD | 22e. ADDRESS | Chestertown, Md. 21620 |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Burial | 23b. DATE | Dec 28 1988 | 23c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery |
| 23d. LOCATION CITY OR TOWN / COUNTY / STATE | Chestertown, Md. | | | |
| 24. FUNERAL DIRECTOR NAME | J. Willis Wells | ADDRESS | J. Willis Wells Chestertown, Md. | 25a. DATE REC'D. BY REGISTRAR: DEC 27 '88 |
| 25b. REGISTRAR'S SIGNATURE | Julia Davidson-Randall | | | |

017051 DEC 22 88 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 369297 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | Robert | Franklin | Turner | 2a. DATE OF DEATH MONTH DAY YEAR | 12 11 88 |
| 2b. HOUR | 0243 AM | | | | |
| 3. SEX | male | 4. RACE | white | 5. DATE OF BIRTH MONTH DAY YEAR | DECEMBER 5, 1903 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 85 YRS | IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS. HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | New Jersey | 7b. CITIZEN OF WHAT COUNTRY? | USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Kent MD. | | | | |
| 10. CITY OR TOWN OF DEATH | Chestertown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Kent & Queen Annes Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Ret. Farmer & A |
| 12b. KIND OF BUSINESS OR INDUSTRY | & P. Employee | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Maryland | 13b. COUNTY | Kent | 13c. CITY OR TOWN | Chestertown |
| 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS | RFD # 3 | 21620 | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | Charles Edward Turner | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Amanda Jones | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | no | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 143 10 3380 | |
| 17. INFORMANT | Jeanne Turner Davis | ADDRESS | RFD #3 Box # Chestertpertown, Md. | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Acute myocardial infarction | 1 hr. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Arteriosclerotic heart disease | > 6 yrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Diabetes Mellitus & H.B.P. | > 6 yrs. |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (~~the hospital~~) attended the deceased from 7-26 19 85 to 12-11 19 88 that (I) (~~we~~) last saw the deceased alive on 12-5 19 88 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE DEGREE | W D Benjamin MD | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED 12/12/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | Wayne D Benjamin, MD | 22e. ADDRESS | Chestertown MD 21620 |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Burial | 23b. DATE | 12/14/88 | 23c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery |
| 23d. LOCATION CITY OR TOWN / COUNTY / STATE | Chestertown, Md. | | | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | J Willis Wells | J. Willis Wells Chestertown, Md. | 25a. DATE REC'D BY REGISTRAR | DEC 12 '88 |
| 25b. REGISTRAR'S SIGNATURE | Julia Davidson-Randall | | | |

BP 20

DHMH - 16 50M 1/81 (VRA 15, 4)

17570 DEC 30 88

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 36930

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then plete pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST: Henry | MIDDLE: G. | LAST: Ablauf | 2a. DATE OF DEATH MONTH: December | DAY: 12 | YEAR: 1988 | 2b. HOUR: 3:30 P.M. |
| 3. SEX: Male | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: Nov. 12, 1906 | 6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD. | | |
| 10. CITY OR TOWN OF DEATH: Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Meridian Healthcare | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Sales | 12b. KIND OF BUSINESS OR INDUSTRY: Steel Abrasives | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Gaithersburg | YES ☐ NO ☒ | 18700 Walkers Choice Road #206 20879 |

| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|---|
| Victor F. Ablauf | Rose Ann Duffy | NO | 167-03-1014 | Dolores A. Rink- Daughter 19823 Mayhill Terr. Gaithersburg, Md. 20879 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: (a) — (b) Months (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that I (this hospital) attended the deceased from August 11, 1988, to December 12, 1988, that I (we) last saw the deceased alive on September 10, 1988, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| [signature] MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/13/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| BENJAMIN AVRUNIN, MD | 18111 Prince Philip Dr. Olney, Md 20832 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | December 12, 1988 | Metropolitan Crem. | Alexandria / Virginia |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| De Vol Funeral Home 10 East Deer Park Drive Gaithersburg, Maryland 20877 | DEC 13 '88 | Julia Davidson-Randall |

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

)16745 DEC 20 88 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO. 36931

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: JACK | MIDDLE | LAST: AIZENBERG | 2a. DATE OF DEATH MONTH DAY YEAR: 12-09-88 | 2b. HOUR: 5:07 PM | |
| 3. SEX: MALE | 4. RACE: CAUC | 5. DATE OF BIRTH MONTH DAY YEAR: 01-23-04 | 6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Poland | 7b. CITIZEN OF WHAT COUNTRY?: Montgomery | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH: SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): TAILOR | 12b. KIND OF BUSINESS OR INDUSTRY: CLOTHING IND. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Montgomery | 13c. CITY OR TOWN: WHEATON | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 1111University Blvd. W. (20902) | |
| 14. FATHER'S NAME FIRST: Joseph | MIDDLE | LAST: Aizenberg | 15. MOTHER'S MAIDEN NAME FIRST: Malka | MIDDLE | LAST: Weissburt |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): ---------- | 16b. SOCIAL SECURITY NO.: 146-24-4362 | 17. INFORMANT: Son-in-Law | ADDRESS: Alfred Traum:1723 Ladd Street:Silver Spring | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Profuse Intracerebral Bleed - Acute — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 hrs
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular disease — 70 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/9, 19 88, to 12/9, 19 88, that (I) (we) last saw the deceased alive on 12/9, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Louise Stomierowski — DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑ — 22c. DATE SIGNED: 12/9/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): LOUISE M. STOMIEROWSKI — 22e. ADDRESS: HOLY CROSS HOSPITAL, KNOLLWOOD RD, SILVER SPRING, MD

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/12/88 | 23c. NAME OF CEMETERY OR CREMATORY: Mt. Lebanon Cemetery | 23d. LOCATION CITY OR TOWN: Adelphi | COUNTY: PG STATE: Md |
| 24. FUNERAL DIRECTOR NAME AND ADDRESS: Danzansky-Goldberg Memorial Chapels, 1170 Rockville Pike;Rockville, Md | | 25a. DATE REC'D BY REGISTRAR: DEC 19 1988 | 25b. REGISTRAR'S SIGNATURE: [signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

18606 JAN 10 89

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 369322

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH | DAY | YEAR | 2b. HOUR |
| THEODORE | S. | AMUSSEN | DECEMBER | 21, | 1988 | 5:50P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH | DAY | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|---|---|
| MALE | CAUCASIAN | AUG | 15 | 1915 | 73 YRS. | | | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| UTAH | USA | MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | MONTGOMERY MD |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| ROCKVILLE | COLLINGSWOOD NURSING HOME | EDITOR IN CHIEF | NAT GALLERY OF ART |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MARYLAND | MONTGOMERY | SILVER SPRING | YES ☐ NO ☒ | 10800 GEORGIA AVE #T-10 20902 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| THEODORE | | AMUSSEN | LORNA | | RUSSELL |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| YES | 1945-1946 | 061-12-7576 | SON DAVID R. AMUSSEN | 2417 ECCLESTON ST. SILVER SPRING, MD 20902 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Brain metastases | 2 mo. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Colon Cancer | 3 yrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Lung + Liver metastases

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I/this hospital) attended the deceased from 12/22/88 to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Peter B. Sherer MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/22/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Peter B. Sherer MD | 3947 Ferrara Dr. Wheaton, md 20906 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| CREMATION | DEC 22, 1988 | METROPOLITAN CREMATORY | ALEXANDRIA | | VA |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25. DATE RECEIVED BY REGISTRAR | 26. REGISTRAR |
|---|---|---|---|
| FRANCIS J. COLLINS, JR. | 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901 | DEC 23 88 | Julie Davidson Randall |

DHMH - 16 50M 4/83
(VRA 15, 4)

0186-44 JAN 10 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 36933
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and pages 3 and 4. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal from the state. A medical examiner must be notified of those deaths marked on page 2.

IMPORTANT: If item 21 is marked on page 2, item 19 should show any injury, or other traumatic event, which caused the death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: ALEASE | MIDDLE: K. | LAST: ANDERSON | 2a. DATE OF DEATH MONTH DAY YEAR: 12-22-88 | 2b. HOUR: 0248 M | |
| 3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: February 26, 1921 | 6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Florida | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED XX / NEVER MARRIED / WIDOWED / DIVORCED | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, | | MD. |
| 10. CITY OR TOWN OF DEATH: Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SHADY GROVE ADVENTIST Hosp. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Own home | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Gaithersburg | YES XX / NO | 149 Watkins Mill Road, #E 20879 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Joseph | C. | Knowles | Ethel | | Fox |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 262-34-1991A | Howard S. Anderson, Husband, Same as #13 | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiopulmonary Arrest | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Adult Respiratory Distress Syndrom | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Hepatorenal Syndrome | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Fulminant Hepatitis, Systemic Lupus Erythematosis?

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO XX | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES / NO |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 16 Dec 8, 19 88, to 22 Dec 22, 19 88, that (I) (we) last saw the deceased alive on 21 Dec 21, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| [signature] | ATTENDING PHYSICIAN X / MEDICAL DIRECTOR / STAFF PHYSICIAN | 22 Dec 88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| KEVIN M. GIL | 15001 Duffief Mill Rd Gaithersburg Md. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec. 28, 1988 | Royal Palm Memorial Gardens | West Palm Beach, Florida |

| 24. FUNERAL DIRECTOR NAME AND ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Robert A. Pumphrey Funeral Home Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850 | 12-23-88 | |

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

017757 DEC 30 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO 036934

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and delivered to the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Leslie (Leslie) Middle: O. (O.) Last: Andrews (Andrews) | | | 2a. DATE OF DEATH Month Day Year: 12 21 88 — 2b. HOUR: 22:45 M |
| 3. SEX: Male | 4. RACE: Black | 5. DATE OF BIRTH Month Day Year: 08 07 1926 | 6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, DC | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD. |
| 10. CITY OR TOWN OF DEATH: Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Accountant | 12b. KIND OF BUSINESS OR INDUSTRY: GEICO |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN: Washington, DC | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS / ZIP CODE: 4813 B Street, SE / 20019 (99999) |
| 14. FATHER'S NAME First Middle Last: Unavailable | | 15. MOTHER'S MAIDEN NAME First Middle Last: Maude Baldwin | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): WW II | 16b. SOCIAL SECURITY NO.: 579-26-8245 | 17. INFORMANT: Geneva B. Vincent, | ADDRESS: 1312 Balfour Court Hyattsville, MD 20782 |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF (b): diabetes mellitus
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic renal failure

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from July 88 (19 88) to Dec 21 (19 88), that (I) (we) last saw the deceased alive on Dec 21 (19 88), and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Mark S Rosen MD | DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12/22/88 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Mark S Rosen MD | 22e. ADDRESS: Silver Spring, MD | | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation | 23b. DATE: 12-22-88 | 23c. NAME OF CEMETERY OR CREMATORY: Suburban Crematory | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Silver Spring, Maryland |
| 24. FUNERAL DIRECTOR NAME: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 | | 25a. DATE REC'D. BY REGISTRAR: DEC 29 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Pendelle |

BP 99999

DHMH - 16 60M 7/84 (VRA 15, 4)

0 1 9 7 4 4 JAN 19 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 3 3 6 9 3 5

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED IN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" (PENCIL IS ACCEPTABLE) IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, REMOVAL

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) — FIRST: James | MIDDLE: L. | LAST: Ashwell Sr. | 2a. DATE KNOWN OF DEATH ☐ ESTIMATED ☐ — MONTH DAY YEAR: Dec 18 1988 | 2b. HOUR: 6 00 ☐A ☒P M | | |
| 3. SEX: male | 4. RACE: White | 5. DATE OF BIRTH — MONTH DAY YEAR: Sept 18 21 | 6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS. | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. | 2c. DATE PRONOUNCED DEAD — MONTH DAY YEAR: Dec 18 1988 — 2d. HOUR: 6 05 ☐A ☒P M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VA. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery Co MD. | | | |
| 10. CITY OR TOWN OF DEATH: Sil. Spg. | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CONTRACTOR | 12b. KIND OF BUSINESS OR INDUSTRY: ROOFING Co. | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | |
| 13a. STATE: Md. | 13b. COUNTY: MONTGOMERY | 13c. CITY OR TOWN: SILVER SPRING | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 10000 COLESVILLE Rd. 20901 | | |
| 14. FATHER'S NAME — FIRST: JAMES | MIDDLE: B. | LAST: ASHWELL | 15. MOTHER'S MAIDEN NAME — FIRST: ANNIE | MIDDLE: | LAST: HOWELL | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): YES | (IF YES, GIVE WAR OR DATES): WWII | 16b. SOCIAL SECURITY NO.: 223-26-7325 | 17. INFORMANT: RUTH ANN ASHWELL | ADDRESS: Rt. 3 Box 315 Millsboro, Del | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Dis.
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): None

| | | |
|---|---|---|
| 19a. DATE OF OPERATION: None | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John S. Rogers M.D. TITLE (SPECIFY): Dep. MEDICAL EXAMINER — DATE SIGNED: Dec 19 1988

EXAMINER'S NAME (TYPE OR PRINT): JOHN S. ROGERS ADDRESS: 1919 SEMINARY Rd. SS, Md.

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: 12-29-1988 | 23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATL. CEM. | 23d. LOCATION CITY OR TOWN: ARLINGTON | COUNTY: ARL Co. STATE: VA. |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: W. W. CHAMBERS Co. INC., SILVER SPRING Md. 20910 | | 25a. DATE REC'D. BY REGISTRAR: DEC 29'88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

07/84 25M BP 3 DHMH - 17 (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

Cleared by Medical examiner

1 - FOR STATE REGISTRAR

REG. NO. 88 3 693

019353 JAN 17 88

1. DECEASED NAME (TYPE OR PRINT): FIRST Marion; MIDDLE A.; LAST Askins
2a. DATE OF DEATH: MONTH December; DAY 18; YEAR 1988
2b. HOUR: 4:36 PM
3. SEX: Female
4. RACE: Black
5. DATE OF BIRTH: MONTH Sept.; DAY 5; YEAR 1910
6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.)
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash. D.C.
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD
10. CITY OR TOWN OF DEATH: Silver Spring
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Domestic
12b. KIND OF BUSINESS OR INDUSTRY: Private Homes

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md.
13b. COUNTY: Montg.
13c. CITY OR TOWN: Wheaton
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE: 12005 Livingston St. /20902

14. FATHER'S NAME: FIRST George; MIDDLE -; LAST Askins
15. MOTHER'S MAIDEN NAME: FIRST Carrie; MIDDLE -; LAST Murphy
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES): -------
16b. SOCIAL SECURITY NO.: 215-04-1652
17. INFORMANT ADDRESS: Susan Cohen 5630 Fishers La. Rockville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 30 Min
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Hypertension.

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from 9/5, 19 87, to 12/18, 19 88, that (I) (~~we~~ last saw the deceased alive on 12/15, 19 88, and that in (my) (~~our~~ opinion death occurred an the date and hour and from the causes stated above, (I) (~~we~~) did not) view the body after death.
22b. SIGNATURE: Carl L. Schoenberger — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/18/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Carl L. Schoenberger
22e. ADDRESS: 4701 Randolph Rd. Rockville.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation
23b. DATE: 12/20/88
23c. NAME OF CEMETERY OR CREMATORY: Chambers Crematory
23d. LOCATION: CITY OR TOWN: Riverdale; COUNTY: P.G.; STATE: Md.
24. FUNERAL DIRECTOR NAME: W.W.Chambers Co. Inc. Silver Spring Md.
ADDRESS: 9241 Columbia Blvd.
25a. DATE RECD. BY REGISTRAR: DEC 21 '88
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The original of this certificate must be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified, or given

BP 1

DHMH - 16 60M 7/84
(VRA 15, 4)

017571 DEC 30 '88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

58 36937
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper sets. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT): First Catherine Middle Rose Last Atkinson
Catherine Rose Atkinson

2a. DATE OF DEATH: Month December Day 7 Year 1988
2b. HOUR: 12 05 pM

3. SEX: FEMALE
4. RACE: White
5. DATE OF BIRTH: Month 12 Day 05 Year 05
6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Alabama
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: Bethesda
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Sales Person Retail Dry Goods
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: Montg.
13c. CITY OR TOWN: Chevy Chase
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 4450 S. Park Ave./20815

14. FATHER'S NAME: First Richard Middle -- Last Vaughn
15. MOTHER'S MAIDEN NAME: First Jenny Middle -- Last Loving

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES): ---
16b. SOCIAL SECURITY NO.: 240-14-6555
17. INFORMANT: William J. McLendon, Matthews, NC
ADDRESS: 1001 ChestnutLa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: one
DUE TO, OR AS A CONSEQUENCE OF (b): one cerebrovascular accident — 11-22-88
DUE TO, OR AS A CONSEQUENCE OF (c): cerebrovascular extension — yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: hypertension

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from 11-22 19 88 to 12-2 19 88, that (I) (~~we~~) last saw the deceased alive on 12-2 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: John S AIA
DEGREE: MD
ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/7/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): John S AIA
22e. ADDRESS: 809 Vliers Mill Rd Rockville MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 12/10/88
23c. NAME OF CEMETERY OR CREMATORY: Forest Lawn East
23d. LOCATION: CITY OR TOWN: Matthews / COUNTY: NC / STATE:

24. FUNERAL DIRECTOR (NAME AND ADDRESS): Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C.
25a. DATE REC'D. BY REGISTRAR: DEC 9 '88
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR — 88 — 36933 — REG. NO.

01901 JAN 13 88

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST: ROSE | MIDDLE: DELORES | LAST: AUDI | 2a. DATE OF DEATH: KNOWN ☑ / ESTIMATED ☐ | MONTH: 12 | DAY: 24 | YEAR: 1988 | 2b. HOUR: 4:15 PM |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: MONTH 08 DAY 17 YEAR 1907 | 6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS. | IF UNDER 1 YR.: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 24 YEAR 1988 | | 2d. HOUR: 4:15 PM |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wisconsin | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH: Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: P.G. | 13c. CITY OR TOWN: Cheverly | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NO.: 2518 Crest Avenue 20785 | | | | |
| 14. FATHER'S NAME: FIRST Charles MIDDLE LAST Herro | 15. MOTHER'S MAIDEN NAME: FIRST Elizabeth MIDDLE LAST Herro | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 395-20-4144 | 17. INFORMANT: Norman M. Audi (Son) | ADDRESS: 2518 Crest Avenue Cheverly, Md. 20785 | | | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Myocardial Infarction | minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Arteriosclerotic Cardiovascular Disease | 4 years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Alzheimers Disease, Hypertension

| | | |
|---|---|---|
| 19a. DATE OF OPERATION: N/A | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☑ |
| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): N/A |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Paul A. Dekker M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 12/25/88

EXAMINER'S NAME (TYPE OR PRINT): Paul A. Dekker MD — ADDRESS: 4203 Queensbury Rd Hyattsville Md 20781

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/28/88 | 23c. NAME OF CEMETERY OR CREMATORY: Washington National Cem. | 23d. LOCATION CITY OR TOWN: Suitland | COUNTY: P.G. STATE: Maryland |
| 24. FUNERAL DIRECTOR NAME AND ADDRESS: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781 | | 25a. DATE REC'D. BY REGISTRAR: JAN 13 '89 | 25b. REGISTRAR'S SIGNATURE: Lucia Davidson-Randall | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3 - RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

019354 JAN 17 '89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO 88 036937

1. DECEASED NAME (TYPE OR PRINT): FIRST Esther MIDDLE A. LAST Azzarel
2a. DATE OF DEATH: MONTH 12 DAY 22 YEAR 88
2b. HOUR: 905 A M
3. SEX: FEMALE
4. RACE: CAUCASIAN
5. DATE OF BIRTH: MONTH AUG DAY 21 YEAR 1903
6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON, DC
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Bethesda
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CLERK
12b. KIND OF BUSINESS OR INDUSTRY: US GOVERNMENT

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY: MONTGOMERY
13c. CITY OR TOWN: BETHESDA
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS: 7254 GREENTREE ROAD 20817

14. FATHER'S NAME: FIRST LOUIS MIDDLE C. LAST RATINO
15. MOTHER'S MAIDEN NAME: FIRST LUCY MIDDLE LAST UNKNOWN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 578-32-9185
17. INFORMANT ADDRESS: ESTHER SERADO/DAUGHTER/SAME AS 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): septic shock — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hours
DUE TO, OR AS A CONSEQUENCE OF
(b): pneumonia — few days
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: gastro intestinal hemorrhage, senile dementia

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) this hospital) attended the deceased from June 19 88 to Dec 22 19 88, that (I) (we) last saw the deceased alive on Dec 22 19 88, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: W. R. Ehrmantraut MD — DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/22/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): W. R. Ehrmantraut
22e. ADDRESS: 11125 Rockville Pike, Rockville Md 20852

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: DEC 24, 1988
23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEM.
23d. LOCATION: CITY OR TOWN SILVER SPRING COUNTY MONTGOMERY STATE MD

24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR.
ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901
25a. DATE REC'D. BY REGISTRAR: DEC 27 '88
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1650M 1/81 (VRA 15, 4)

016681 DEC 20

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 36940

1. DECEASED NAME (TYPE OR PRINT): FIRST EDITH MIDDLE LAST BAER
2a. DATE OF DEATH: MONTH 12 DAY 11 YEAR 88
2b. HOUR: 8:22 AM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: MONTH 3 DAY 02 YEAR 04
6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: Bethesda
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker
12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Bethesda
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS: 10250 Westlake Drive, #105 (20817)

14. FATHER'S NAME: FIRST Jacob MIDDLE LAST Goss
15. MOTHER'S MAIDEN NAME: FIRST Ann MIDDLE LAST Wilson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
(IF YES, GIVE WAR OR DATES): ------
16b. SOCIAL SECURITY NO.: 579-14-2979
17. INFORMANT ADDRESS: Alice Lyon;Daughter;18 Starlight Ct.;Rockville Maryland 20854

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary Arrest. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO, OR AS A CONSEQUENCE OF (b): Arrythmia
DUE TO, OR AS A CONSEQUENCE OF (c): Severe Coronary Artery Disease — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-11 19 88 to 12-11 19 88, that (I) (we) last saw the deceased alive on 12-11 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Loreto S. Albiol, MD — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12-11-88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): LORETO S. ALBIOL, MD
22e. ADDRESS: 6121 MONTROSE Rd

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 12/13/88
23c. NAME OF CEMETERY OR CREMATORY: Judean Memorial Gdns
23d. LOCATION CITY OR TOWN: Olney COUNTY: Montgomery STATE: Maryland

24. FUNERAL DIRECTOR NAME AND ADDRESS: DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852
25. DATE RECD. BY REGISTRAR: DEC 19 1988

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED BY M.E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

016003 2015

REG. NO. 3 3 6 9 4 1

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST: Aziz | MIDDLE: Ilias | LAST: BARAKAT | 2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ | MONTH: 12 | DAY: 2 | YEAR: 88 | 2b. HOUR: 3:49 P.M. | | | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: MONTH 7 | DAY 14 | YEAR 17 | 6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS. | IF UNDER 1 YR.: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN | 2c. DATE PRONOUNCED DEAD: MONTH 12 | DAY 2 | YEAR 88 | 2d. HOUR: 3:49 P.M. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Lebanon | 7b. CITIZEN OF WHAT COUNTRY?: Lebanon | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery Co. MD | | | | | | | | |
| 10. CITY OR TOWN OF DEATH: Bethesda | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Diplomat | 12b. KIND OF BUSINESS/INDUSTRY: United Nations | | | | | | | | |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Silver Spring | YES ☐ NO XX | 12050 Eaglewood Court/20902 |

| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | | | |
|---|---|---|---|---|---|
| FIRST: Ilias | MIDDLE: | LAST: Barakat | FIRST: Mary | MIDDLE: | LAST: Saraf |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 078-70-4899 | Miss Zeina C. Barakat, Daughter, | Same #13 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

- IMMEDIATE CAUSE (a): CARDIORESPIRATORY ARREST
- DUE TO, OR AS A CONSEQUENCE OF (b): CEREBRAL TRAUMA.
- DUE TO, OR AS A CONSEQUENCE OF (c): PARKINSONS DISEASE

8809

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS UNDERLYING ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
|---|---|---|---|
| | 12 (P.M) 12-2-88 | FELL DOWN STAIRS | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN / COUNTY / STATE |
| | HOME | 12050 EAGLEWOOD COURT | SILVER SPRING MD. |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John Tauber M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 12-2-88

EXAMINER'S NAME (TYPE OR PRINT): John Tauber ADDRESS: 8218 Wisconsin Bethesda MD Ave.

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | Dec. 3, 1988 | Ft. Lincoln Cemetery | Brentwood, | Maryland | |

24. FUNERAL DIRECTOR NAME: Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814

25. DATE REC'D. BY REGISTRAR: DEC 5 '88

26. SIGNATURE: Julia Davidson Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP 10

DHMH - 17 (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 88 036942

016256 DEC 15 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | ELIZABETH MAY BARNES | 2a. DATE OF DEATH MONTH DAY YEAR | NOVEMBER 27 1988 | 2b. HOUR | 1:38 P M |
| 3. SEX | FEMALE | 4. RACE | CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR | FEBRUARY 20 1929 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 59 YRS | IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS. HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY? | UNITED STATES | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH | BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | NAVAL HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | NURSE |
| 12b. KIND OF BUSINESS OR INDUSTRY | HEALTH CARE | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | DISTRICT OF | 13b. COUNTY | COLUMBIA | 13c. CITY OR TOWN | |
| 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET ADDRESS | 1301 15th STREET, NW 20002 | | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | JAMES PRENTICE | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | ELLA MAY BUCKWALTER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | NO | (IF YES, GIVE WAR OR DATES) | - | 16b. SOCIAL SECURITY NO. | 171-22-6124 |
| 17. INFORMANT ADDRESS | JAMES P.BARNES, 342 E. CHESTNUT STREET, COATESVILLE, PA 19320 | | | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SMALL CELL CARCINOMA OF THE LUNG
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☒ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 14, 1988, to NOVEMBER 27 1988, that (I) (we) last saw the deceased alive on NOVEMBER 27 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | R J Morrissey M.D. | DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ | 22c. DATE SIGNED 30 NOV 88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | R. L. MORRISSEY, LCDR, MC, USN | 22e. ADDRESS | NAVAL HOSPITAL BETHESDA, MD 20814-5011 |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | cremation | 23b. DATE | 12-2-88 | 23c. NAME OF CEMETERY OR CREMATORY: R.A. FERRIS & Co. |
| 23d. LOCATION CITY OR TOWN / COUNTY / STATE | West Chester Chester Pa | | | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | R.T. FORD FUNERAL HOME Suitland MD 20746 | 25a. DATE REC'D. BY REGISTRAR | DEC 14 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

BP

DHMH -16 50M 1/81 (VRA 15, 4)

19038 JAN 13 89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO 88 369 43

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. DECEASED NAME (TYPE OR PRINT) | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
|---|---|---|---|---|---|---|---|---|
| | Laal | E. | Barnhart | | Dec. | 26 | 1988 | 9:15 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
|---|---|---|---|---|---|---|---|
| | | MONTH DAY YEAR | | MONTHS | DAYS | HOURS | MIN. |
| Female | White | Aug. 6 1916 | 72 YRS. | | | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| New York | U. S. A. | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | Montgomery MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Chevy Chase | 7108 Brennon Lane | Homemaker | Own Home |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | Mont. | Chevy Chase | YES [X] NO [ ] | 7108 Brennon Lane 20815 |

| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | |
|---|---|---|---|---|---|
| FIRST | MIDDLE | LAST | FIRST | MIDDLE | LAST |
| William | A | Peck | Martha | | Hillick |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 215-48-8139 | Gilbert R. Barnhart | Same as item # 13 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CARDIAC ARREST | 1 HR |
| DUE TO, OR AS A CONSEQUENCE OF (b) | CEREBRAL INFARCTION | 3 DAYS |
| DUE TO, OR AS A CONSEQUENCE OF (c) | CEREBRAL ARTERIOSCLEROSIS | 12 YRS |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| [ ] | | |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19 72, to Dec, 19 88, that (I) (we) last saw the deceased alive on Sept 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Marvin Fuchs MD | ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 12-27-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Marvin Fuchs, M. D. | 5315 Conn. Ave. NW Washington, D.C. 20015 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | 12/30/88 | Parklawn Cem. | Rockville, MD | | |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Joseph Gawler's Sons, Inc. | 5130 WI Ave. NW Wash., DC 20016 | DEC 28 '88 | Julia Davidson-Randall |

BP 7.00

DHMH - 16 50M 1/81 (VRA 15, 4)

0 1 5 5 4 2 DEC -7

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove white paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

33 REG. NO. 36944

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Elizabeth Middle: T. Last: Barnette | | | | 2a. DATE OF DEATH Month Day Year: 12-4-88 | 2b. HOUR: 725 AM |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH Month Day Year: 5 14 21 | 6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS. | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, DC | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County. | | ID. |
| 10. CITY OR TOWN OF DEATH: Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Food Processor | 12b. KIND OF BUSINESS OR INDUSTRY: Restaurant | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Kensington | YES ☒ NO ☐ | 3416 Oberon Street / 20895 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last | | |
|---|---|---|---|
| Joseph / Theron / Ruppert | Thelma / Katherine / Bachman | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 578-20-3982 | 17. INFORMANT ADDRESS: Michael A. Barnette, Same as 13 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | RESPIRATORY FAILURE | 24 hours |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) | METASTATIC ADENOCARCINOMA | 8 month |
| DUE TO, OR AS A CONSEQUENCE OF (c) | LUNG CANCER | 14 month |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Massive Lymphedema of Right Leg

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from Nov 20, 19 87, to Dec, 19 88, that (I) (we) last saw the deceased alive on Dec 1, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
|---|---|---|---|
| E P Libre | MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): EUGENE P. LIBRE MD | 22e. ADDRESS: 10400 CONNECTICUT AVE KENSINGTON, MD. 20895 | | |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | 12-5-88 | Baltimore-Washington Crem. | Laurel, Maryland |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 | DEC 6 1988 | |

DEC 1988 FOR 1 - STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

88 REG. NO. 36945

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| FRANCIS | JOHNSON | BEANE JR. | DECEMBER 3, 1988 | 12:20PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | NOVEMBER 16, 1940 | 48 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| WASHINGTON, DC | UNITED STATES | | MONTGOMERY COUNTY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| BETHESDA | NIH, THE CLINICAL CENTER | PARA LEGAL | INTERSTATE COM |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MARYLAND | MONTGOMERY | SILVER SPRING | YES [ ] NO [ ] | 9907 WOODBURN RD. 20901 |

MERCE COMMISS.

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| FRANCIS | J. | BEANE, SR. | HELEN | | RYAN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 213-38-4125 | MRS. MARY PATRICIA BEANE | 9907 WOODBURN RD. SILVER SPRING, MD 20901 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | RESPIRATORY FAILURE | 1 week |
| DUE TO, OR AS A CONSEQUENCE OF (b) | ANGIO IMMUNOBLASTIC LYMPHODENOPATHY | 18 months |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [X] NO [ ] | YES [X] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I/this hospital) attended the deceased from DECEMBER 8, 19 87, to DECEMBER 3, 19 88, that (I/we) last saw the deceased alive on DECEMBER 3 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Chris Johnson | ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X] | 12-3-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Chris Johnson | NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| BURIAL | DEC 7,1988 | GATE OF HEAVEN CEM. | SILVER SPRING MONTGOMERY MD |

| 24. FUNERAL DIRECTOR NAME ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901 | DEC 6 '88 | Julia Davidson Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

015547 DEC -7 88

1. FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO 369456

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | Sylvia D Becker | 2a. DATE OF DEATH MONTH DAY YEAR | December 2, 1988 |
| | | 2b. HOUR | 2:50 PM |
| 3. SEX | Female | 4. RACE | White |
| 5. DATE OF BIRTH MONTH DAY YEAR | April 3, 1908 | 6. AGE (IN YEARS LAST BIRTHDAY) | 80 YRS |
| IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Wisconsin | 7b. CITIZEN OF WHAT COUNTRY? | U. S. A. |
| 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XXX DIVORCED ☐ | | 9. BALTIMORE CITY OR COUNTY OF DEATH | Montgomery MD. |
| 10. CITY OR TOWN OF DEATH | Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Fernwood Nursing Home |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Welfare Worker | 12b. KIND OF BUSINESS OR INDUSTRY | U.S. Gov't |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Md | 13b. COUNTY | Montgomery |
| 13c. CITY OR TOWN | Bethesda | 13d. INSIDE CITY LIMITS? YES XX NO ☐ | 13e. STREET ADDRESS 5524 Charles Street 20814 |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | Joseph Dermansky | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Bertha Bersansky |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | No | (IF YES, GIVE WAR OR DATES) | |
| 16b. SOCIAL SECURITY NO. | 469-22-4412 | 17. INFORMANT ADDRESS | Dr. Karin Nelson (Same as # 13) |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

9289

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Days / Week

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Senile Dementia. Bladder Carcinoma. Bilateral subdural hematoma (7/88)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES XXX NO ☐ | Head Only | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ | |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from middle of, 19 86, to present, 19 88, that (I) (he) last saw the deceased alive on November 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Patricia D Kellogg | DEGREE | MD |
| ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | | 22c. DATE SIGNED | 12/3/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | Patricia Kellogg | 22e. ADDRESS | 809 Veirs Mill Rd, Rockville, Md |

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Cremation | 23b. DATE | 12/4/1988 | 23c. NAME OF CEMETERY OR CREMATORY | Metropolitan Crematory |
| 23d. LOCATION CITY OR TOWN / COUNTY / STATE | Alexandria, Virginia | | | | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C. | 25a. DATE REC'D. BY REGISTRAR | DEC 6 1988 | 25b. REGISTRAR'S SIGNATURE | |

BP

DHMH - 16 50M 1/81 (VRA 1S, 4)

016893 DEC 2

"A"

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 369 47

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: BABY GIRL | MIDDLE: | LAST: Beebe | 2a. DATE OF DEATH MONTH DAY YEAR: 12 14 88 | 2b. HOUR: 0247 M | | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR: 12 14 88 | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS: 1 / MIN: 35 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): md. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH: Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): NONE | 12b. KIND OF BUSINESS OR INDUSTRY: NONE | | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| md | MONTGOMERY | Olney | YES ☐ NO ☒ | 18012 Rocky Ridge Ln 20832 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Eric | XX | Beebe | Ellen | | FRADIN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | NONE | ERIC BEEBE 18012 ROCKY RIDGE LANE 20832 | OLNEY, MD |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): severe immaturity

DUE TO, OR AS A CONSEQUENCE OF (b): respiratory insufficiency

DUE TO, OR AS A CONSEQUENCE OF (c): cardiac arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Mary Lenore Keszler MD | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐ | 12/14/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| MARY LENORE KESZLER, MD. | HOLY CROSS HOSPITAL |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 12/16/88 | BNAI ISRAEL CEMETERY | BALTIMORE, MARYLAND |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | DEC 19 1988 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, air other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 7/77 (VR A 15 (4))

016892 DEC 2 '88

"B" FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36948 REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: BABY GIRL MIDDLE: LAST: Beebe | 2a. DATE OF DEATH MONTH DAY YEAR: 12 14 88 | 2b. HOUR: 0413 M | | | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR: 12 14 88 | 6. AGE (IN YEARS LAST BIRTHDAY) YRS | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS 2 / MIN 30 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH: Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): NONE | 12b. KIND OF BUSINESS OR INDUSTRY: NONE | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Md | MONTGOMERY | Olney | YES ☐ NO ☒ | 18012 Rocky Ridge Ln. 20832 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Eric XX Beebe | Ellen FRADIN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | NONE | ERIC BEEBE | 18012 ROCKY RIDGE LANE OLNEY, MD 20832 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): severe prematurity

DUE TO, OR AS A CONSEQUENCE OF: (b): respiratory insufficiency

DUE TO, OR AS A CONSEQUENCE OF: (c): cardiac arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Mary Lenore Keszler MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/14/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| MARY LENORE KESZLER, MD. | HOLY CROSS HOSPITAL |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR COUNTY / STATE |
|---|---|---|---|
| BURIAL | 12/16/88 | BNAI ISRAEL CEMETERY | BALTIMORE, MARYLAND |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | DEC 19 1988 | [signature] |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

016668 DEC 19 88

1a FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 369 49 REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) First / Middle / Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|
| DONALD EDWIN BEEBE | DECEMBER 6 1988 | 12:25 P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH Month Day Year | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
|---|---|---|---|---|---|
| MALE | CAUCASIAN | SEPTEMBER 6 1921 | 67 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| OHIO | UNITED STATES | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | MONTGOMERY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| BETHESDA | NAVAL HOSPITAL | RETIRED | U.S.A.F. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| VIRGINIA | FAIRFAX | ANNANDALE | YES [ ] NO [ ] | 4473 FOREST GLEN COURT 22003 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last |
|---|---|
| WALLACE G. BEEBE | HENRIETTA BIGGS |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | 17. INFORMANT ADDRESS |
|---|---|---|
| YES | 1942-1966 280-14-1633 | FLORENCE E. BEEBE, 4473 FOREST GLEN COURT, ANNANDALE, VA 22003 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) RESPIRATORY ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) SQUAMOUS CELL CANCER OF NECK

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | | |

22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 2, 19 88, to DECEMBER 6, 19 88, that (I) (we) last saw the deceased alive on DECEMBER 6, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Scott R. Schoem | MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X] | 7 Dec 88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| SCOTT R. SCHOEM, LT, MC, USN | NAVAL HOSPITAL BETHESDA, MD 20814-5011 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | 12/8/88 | Smithsburg Crematory | Smithsburg Washington Maryland |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Gerald N. Minnich | 305 N. Potomac Street Hagerstown, Maryland | DEC 09 '88 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

018645 JAN 10 89 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 369 50 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Ortha | A. | Beecher | December 18, 1988 | 12:45 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
|---|---|---|---|---|---|
| Female | Caucasian | November 9, 1917 | 71 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Iowa | United States | | Montgomery County, MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Bethesda | Suburban Hospital | Homemaker | Own Home |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Rockville | YES ☒ NO ☐ | 536 W. Montgomery Ave./20850 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Not available | | | Angie | | Christiansen |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | - | 479-18-7100 | David W. Beecher, Husband, Same as #13 |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CARDIO - RESPIRATORY ARREST | SAME HOUR |
| DUE TO, OR AS A CONSEQUENCE OF (b) | SEPTIC SHOCK | 8-10 hrs - |
| DUE TO, OR AS A CONSEQUENCE OF (c) | DISEMINATED INTRAVASCULAR COAGULATION | 8-10 hr |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): GANGRENE BOTH FEET

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 17 19 88, to December 17 19 88, that (I) (we) last saw the deceased alive on December 17 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| | ATTENDING PHYSICIAN XX MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | Dec. 19, 1988 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Mario O. Belledonne, M.D. | 14815 Physicians Lane, #251, Rockville, MD 20850 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | December 20, 1988 | Montgomery Crematorium | Bethesda / Maryland |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Robert A. Pumphrey Funeral Home/ Rockville, Inc. | 300 W. Montgomery Avenue, Rockville, Maryland | 12/20/88 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RELEASED BY Medical Examiner

BP

DHMH - 1650M 1/81 (VRA 15, 4)

18151 JAN -5 89

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 5 3 5 9 5 1

DECEASED NAME (TYPE OR PRINT): FIRST ANNIE MIDDLE LAST BELL

2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ MONTH 12 DAY 27 YEAR 1988 — 2b. HOUR P M

3. SEX: F — 4. RACE: B — 5. DATE OF BIRTH: MONTH 04 DAY 15 YEAR 01 — 6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN

2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 27 YEAR 1988 — 2d. HOUR 1640 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Georgia — 7b. CITIZEN OF WHAT COUNTRY?: United States — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: BETHESDA — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 6023 McKINLEY ST — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Assembly Line — 12b. KIND OF BUSINESS OR INDUSTRY: Automobile

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD — 13b. COUNTY: MONTGOMERY — 13c. CITY OR TOWN: BETHESDA — 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ — 13e. STREET ADDRESS: 6023 McKinley St 20817

14. FATHER'S NAME FIRST Walter Reed MIDDLE LAST

15. MOTHER'S MAIDEN NAME FIRST Fannie MIDDLE Lane LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 368-20-9014

17. INFORMANT: Curtiss E. Knighton, 6023 McKinley St., ADDRESS: Bethesda, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ACUTE

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — INDEF

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): ALZHEIMERS DISEASE

19a. DATE OF OPERATION: — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?: — 20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS: UNDERLYING ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY: HOUR A.M. P.M. MONTH 12 DAY 27 YEAR 1988 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): FOUND DEAD IN BED

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): HOME — 21f. LOCATION: STREET 6023 McKinley St CITY OR TOWN Bethesda COUNTY Mont STATE Md

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Francis C Mayle M.D. — TITLE (SPECIFY): SEPT MEDICAL EXAMINER — DATE SIGNED: 12/27/88

EXAMINER'S NAME (TYPE OR PRINT): FRANCIS C MAYLE — ADDRESS: 8100 Wisconsin Ave Bethesda MD 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal — 23b. DATE: 12/30/88 — 23c. NAME OF CEMETERY OR CREMATORY: — 23d. LOCATION CITY OR TOWN: Detroit, Michigan COUNTY STATE

24. FUNERAL DIRECTOR NAME: McGuire Funeral Serv., ADDRESS: 7400 Georgia Ave. N.W. Washington, D.C. — 25a. DATE REC'D. BY REGISTRAR: JAN 3 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07 84 25M BP

DHMH - 17 (VR A15 ME (5))

018646 JAN 10 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

B3 36952 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - REMOVAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ MONTH | DAY | YEAR | 2b. HOUR |
| Benjamin | Francis | Bell | 12/18 | | 19 88 | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR | 2d. HOUR |
| Male | White | Feb. 1, 1913 | 75 YRS. | | | 12/18 19 88 | 1:37 P. M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Washington, D.C. | United States | | Montgomery County MD | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Rockville | 5710 Crawford Drive | Produce Dealer | Self Employed | | | | |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Rockville | YES ☒ NO ☐ | 5710 Crawford Drive / 20851 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Milton | | Bell | Martha | | Branson |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | N/A | 579-14-3693 | (daughter) Joanne M. Pair | 5710 Crawford Drive Rockville, Maryland 20851 |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic carcinoma

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) carcinoma of the colon.

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | | None |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 12/19/88

EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. ADDRESS 1919 Seminary Road Silver Spring, Montgomery County, MD

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | Dec. 20, 1988 | Montgomery Crematorium, Inc. | Bethesda, Montgomery, MD. |

| 24. FUNERAL DIRECTOR | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 W. Montgomery Avenue Rockville, Maryland 20850 | DEC 20 '88 | Julia Davidson-Randall |

07/84 25M BP 3

DHMH - 17 (VR A15 ME (5))

019751 JAN 19 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 36953 REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| EARL | F. | BELL | DECEMBER 28, 1988 | 2:37 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | CAUCASIAN | JUNE 10 1925 | 63 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| WASHINGTON, DC | USA | | MONTGOMERY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| TAKOMA PARK | 8317 HADDON DRIVE | HEAVY EQUIP OPERATOR | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MARYLAND | MONTGOMERY | TAKOMA PARK | YES [X] NO [ ] | 8317 HADDON DRIVE 20912 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| EARL | F. | BELL, SR. | ANNIE | Stanley | Tabb |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| YES | 1943-1945 | 579-20-8799 | SHERRI Brenneman-Bell/wife/same as 13 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC PROSTATE CANCER
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 7/11/88, 19__, to 12/15/88, 19__, that (I) (we) last saw the deceased alive on 12/13, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Dennis A Priebat MD | ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] | 12/28/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DENNIS A. PRIEBAT, M.D. | 110 IRVING ST., NW RM2A70 WASHINGTON, DC |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | DEC 30, 1988 | FT. LINCOLN CEMETERY | BRENTWOOD PRINCE GEORGES MD |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| FRANCIS J. COLLINS, JR. | 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901 | DEC 29 '88 | Jacqueline Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please mail the remaining papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic agent, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 2011

DHMH - 16 50M 1/81 (VRA 15, 4)

018164 JAN 5 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 REG. NO. 36954

FOR 1 - STATE REGISTRAR Nell E. Bell

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Nell | MIDDLE: E. | LAST: Bell

2a. DATE OF DEATH — MONTH DAY YEAR: 12-30-88 | 2b. HOUR: 11 05 AM

3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH — MONTH DAY YEAR: FEB. 29, 1896 | 6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS. | IF UNDER 1 YEAR: MONTHS DAYS | IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Va. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Gaithersburg | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wilson Health Care | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Purchasing Off. | 12b. KIND OF BUSINESS OR INDUSTRY: Government

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md. | 13b. COUNTY: Mont. | 13c. CITY OR TOWN: Gaithersburg | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS / ZIP CODE: 401 Russell Ave. 20877

14. FATHER'S NAME — FIRST: Joseph | MIDDLE: W. | LAST: Erwin
15. MOTHER'S MAIDEN NAME — FIRST: Louise | MIDDLE: - | LAST: Belt

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 578-66-5501 | 17. INFORMANT: William Beebe | ADDRESS: 8507 Redwood Dr. Vienna, Va. 22180

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 mo.
DUE TO, OR AS A CONSEQUENCE OF
(b): Arteriosclerotic Heart. Dis. — 1 1/2 years
DUE TO, OR AS A CONSEQUENCE OF
(c): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Diabetes Mellitus, Congestive Heart failure

19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from April 15, 19 74, to Dec 30, 19 88, that (I)(we) last saw the deceased alive on Dec 30, 19 88, and that in (my)(our) opinion death occurred on the date and hour and from the causes stated above. (I)(we) (did) (did not) view the body after death.

22b. SIGNATURE: James R. Moore MD | DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12-30-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): James R. Moore Jr. | 22e. ADDRESS: 207 Brookes Ave Gaithersburg Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation | 23b. DATE: Jan. 1, 1989 | 23c. NAME OF CEMETERY OR CREMATORY: Balt. Wash. Crematory | 23d. LOCATION CITY OR TOWN COUNTY STATE: Laurel Mont. Md.

24. FUNERAL DIRECTOR NAME: Muriel H. Barber | ADDRESS: Laytonsville, Md. 20879 | 25a. DATE REC'D BY REGISTRAR: JAN 3 1989 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

17572 DEC 30 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

REG. NO. 88 036955

1. DECEASED NAME (TYPE OR PRINT): FIRST William MIDDLE James LAST Benjamin Jr.

2a. DATE OF DEATH: MONTH December DAY 6 YEAR 1988

2b. HOUR: 5:45a M

3. SEX: Male

4. RACE: Caucasian

5. DATE OF BIRTH: MONTH November DAY 16 YEAR 1906

6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS. IF UNDER 1 YEAR: MONTHS DAYS. IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New Jersey

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 10661 Weymouth Street #3

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Master Chief

12b. KIND OF BUSINESS OR INDUSTRY: U.S.N.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Bethesda

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 10661 Weymouth Street #3/20814

14. FATHER'S NAME: FIRST William MIDDLE James LAST Benjamin Sr.

15. MOTHER'S MAIDEN NAME: FIRST Clara MIDDLE LAST Terhune

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes

16b. (IF YES, GIVE WAR OR DATES): WW II

16b. SOCIAL SECURITY NO.: 144-14-5869

17. INFORMANT ADDRESS: Allan T. Benjamin 1010 Bates Avenue Los Angeles, Caiifornia 90029 (Son)

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cancer of the Prostate — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 13 OCT 19 88 to 29 OCT 19 88, that (I) (we) last saw the deceased alive on 29 OCT 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Douglas B. Robinson DEGREE: MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED: December 6, 1988

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Douglas Robinson M.D.

22e. ADDRESS: National Naval Medical Hospital Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: December 9, 1988

23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery

23d. LOCATION CITY OR TOWN: Arlington COUNTY: Virginia STATE

24. FUNERAL DIRECTOR NAME: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. ADDRESS: 7557 Wisconsin Avenue Bethesda, Maryland 20814

25a. DATE REC'D. BY REGISTRAR: DEC 9 '88

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

016823 DEC 21-88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 6 9 5 6

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ MONTH | DAY | YEAR | 2b. HOUR |
| Armell | Walker | Bennett | 12 | 17 | 19 88 | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR | 2d. HOUR |
| Female | Black | 05 02 63 | 25 YRS. | | | 12 17 19 88 | 7:55A M |

| | | | |
|---|---|---|---|
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
| New Jersey | U.S.A. | | Montgomery County MD |

| | | | |
|---|---|---|---|
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| Silver Spring | Holy Cross Hospital (DOA) | Office Assistant | Marine |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| Md. | Montgomery | Silver Spring | YES ☒ NO ☐ | 10900 Bucknell Drive, Apt. 644 20902 |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | |
| Eugene | Walker | Juanita | Wright |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | 17. INFORMANT ADDRESS | |
| No | 136-66-8722 | Christopher H. Bennett III | 10900 Bucknell Drive, Apt. 644 20902 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Multiple injuries | |
| Conditions, if any, which gave rise to immediate couse (a) stating the underlying couse last. DUE TO, OR AS A CONSEQUENCE OF (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☒ NO ☐ |
| | | |

| | | |
|---|---|---|
| 21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
| | 7:10~~PM~~ 12 17 19 88 | Driver in auto/fixed object impacts |

| | | |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
| | road | Viers Mill Rd. Silver Spring Mont. MD |

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Mario F. Golle Jr. M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 12/18/88

EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. ADDRESS 111 Penn St. Balto.MD.

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
| Removal | 12-22-88 | Franklin Memorial Park | North Brunswick New Jersey |

| | | | |
|---|---|---|---|
| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| Redd Funeral Home | 1727 N. Monroe St. 21217 | DEC 19 1988 | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN [illegible] AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL. [illegible] PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 3 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

017298 DEC 27 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

88 36957 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Mary | MIDDLE: V | LAST: Bennett

2a. DATE KNOWN OF DECEASED / ESTIMATED DEATH — MONTH DAY YEAR: Dec 16 1988 — 2b. HOUR: 38 AM

3. SEX: F — 4. RACE: W — 5. DATE OF BIRTH MONTH DAY YEAR: Feb 20 10 — 6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD — MONTH DAY YEAR: Dec 16 1988 — 2d. HOUR: 2201 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD

10. CITY OR TOWN OF DEATH: Tak Park — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wash. Adventist Hosp — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): REGISTERED NURSE — 12b. KIND OF BUSINESS OR INDUSTRY: NURSING

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md — 13b. COUNTY: Mont — 13c. CITY OR TOWN: Tak Park — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 7300 Birch St. 20912

14. FATHER'S NAME — FIRST / MIDDLE / LAST: CARBINE

15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST: NOT AVAILABLE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 577-14-1449

17. INFORMANT — ADDRESS: DALE A. BENNETT CENTREVILLE MD

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Dis

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John Rogers M.D. — TITLE (SPECIFY): Dep — MEDICAL EXAMINER — DATE SIGNED: Dec 16, 1988

EXAMINER'S NAME (TYPE OR PRINT): Dr. John Rogers. — ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: Dec. 21. 1988 — 23c. NAME OF CEMETERY OR CREMATORY: Date Of Heaven Cemetery — 23d. LOCATION CITY OR TOWN: Silver Spring — COUNTY — STATE: MD

24. FUNERAL DIRECTOR (NAME): J. Arthur Kellers — Takoma Funeral Home Inc. 254 Carroll St. N. W. D. C.

25a. DATE REC'D. BY REGISTRAR: DEC 21 1988 — 25b. REGISTRAR'S SIGNATURE: Lois Linder Rogers

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-4. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

15 07/84 25M BP

DHMH - 17 (VR A15 ME (5))

015920 DEC 13 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 036958 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Lona | MIDDLE: C | LAST: Benson | 2a. DATE OF DEATH MONTH: 12 DAY: 6 YEAR: 88 | 2b. HOUR: 9:37 A M | |
| 3. SEX: F | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH: 6 DAY: 2 YEAR: 00 | 6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS | IF UNDER 1 YEAR MONTHS: DAYS: | IF UNDER 24 HRS. HOURS: MIN.: |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hosp | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Seamstress | 12b. KIND OF BUSINESS OR INDUSTRY: Garment | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: WV | 13b. COUNTY: Morgan | 13c. CITY OR TOWN: Paw Paw | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET ADDRESS: Winchester Street | |
| 14. FATHER'S NAME FIRST: Dyre | MIDDLE: | LAST: Sponaugle | 15. MOTHER'S MAIDEN NAME FIRST: Unknown | MIDDLE: | LAST: |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS: Pearl Kunze, 4800 Topping Road, Rockville, Md | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b) hemorrhagic Shock
DUE TO, OR AS A CONSEQUENCE OF (c) ruptured abdominal aortic aneurysm
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: 12-5-88 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Abdominal Aortic Aneurysm | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/5, 19 88, to 12/6, 19 88, that (I) (we) last saw the deceased alive on 12/6, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: Robert L Fox | DEGREE: MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12/6/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Robert L. Fox MD | 22e. ADDRESS: 18111 Prince Philip Dr. Olney, Md. | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/9/88 | 23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Cumberland, Allegany, Md. |
| 24. FUNERAL DIRECTOR NAME: Kenneth Burkhammer | ADDRESS: Helsley-Johnson F.H. Berkeley Springs, WV 25411 | 25a. DATE REC'D. BY REGISTRAR: DEC 12 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landers |

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

0181589 JAN -5 '89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36959
REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Rose | | Berger | 12/29/88 | 5:00 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | MARCH 17, 1894 | 94 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| LITHUANIA | U. S. A. | | MONTGOMERY COUNTY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| ROCKVILLE | HEBREW HOME OF GREATER WASHINGTON | MERCHANT | GROCERY |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MARYLAND | MONTGOMERY | ROCKVILLE | YES ☒ NO ☐ | 6121 MONTROSE ROAD 20852 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| HILLEL | | ISEN | GLICKA | | PLOTSKY |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 218-54-7493 | EVELYN B. CASEL, 5225 POOKS HILL ROAD | BETHESDA, MARYLAND |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 3/30, 19 82, to 12/29, 19 88, that (I) (we) last saw the deceased alive on 12/29, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Merlyn Vemury | MD | 12/29/88 |

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| MERLYN VEMURY MD | |

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 1/1/1989 | OHEV SHOLOM TALMUD TORAH CONGREGATION CEMETERY | WASHINGTON D. C. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C. | JAN 3 1989 | Julia Davidson-Kamara |

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

019764 JAN 19 88 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 3 6960 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ribbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of facts.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: URIE | MIDDLE: F. | LAST: BERGERON | 2a. DATE OF DEATH MONTH DAY YEAR: 12-23-88 | 2b. HOUR: 935 AM | |
| 3. SEX: FEMALE | 4. RACE: CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR: APRIL 25, 1906 | 6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH: TAKOMA PARK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): BEAUTICIAN | 12b. KIND OF BUSINESS OR INDUSTRY | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MARYLAND | MONTGOMERY | SILVER SPRING | YES ☐ NO ☐ | 8750 GEORGIA AVENUE 20910 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| ALLEN / FOSTER | LAURA / CHILDRESS |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 578-05-5062 | SON ROBERT D. BERGERON | 319 LADSON ROAD SILVER SPRING, MD. 20901 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC CARCINOID OF THE ILEUM — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 WKS
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☑ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (~~this hospital~~) attended the deceased from NOVEMBER 14 19 88, to DECEMBER 23 19 88, that (I) (we) last saw the deceased alive on DECEMBER 22 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| James A. Brown MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/23/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| JAMES A BROWN, MD | 1408 PHYSICIANS LANE ROCKVILLE MD 20850 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | DEC. 28, 1988 | CEDAR HILL CEMETERY | SUITLAND PR. GEO. MARYLAND |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901 | DEC 27 '88 | Julia Davidson-Randall |

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

88 036961
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1

0183027 JAN 9 1989

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| JOHN | A | BERZUBS | DECEMBER 17, 1988 | 6:30P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | CAUCASIAN | JAN 17 1909 | 79 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| RUSSIA | USA | | MONTGOMERY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| SILVER SPRING | 8712 COLESVILLE ROAD #110 | TRANSLATOR | N.S.A. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MARYLAND | MONTGOMERY | SILVER SPRING | YES ☐ NO ☐ | 8712 COLESVILLE RD #110 20910 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| UNKNOWN | | | | UNKNOWN | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 067-30-6702 | FRIEND JULIANNA D. SIMMONS | 10247 GREEN HOLLY TERRACE SILVER SPRING MD 20902 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH, EXTENSIVE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 MONTHS

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 7-14-88 | ABOVE | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from AUGUST 16, 19 83 to PRESENT, 19 ____, that (I) (we) last saw the deceased alive on Nov. 15, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| JOHN P. NASON, MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12-19-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| J. Nason, MD | 900 PERSHING DRIVE #105N SILVER SPRING, MD 20910 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| CREMATION | DEC 19, 1988 | METROPOLITAN CREMATORY | ALEXANDRIA VA |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901 | DEC 20 '88 | Julia Davidson-Randall |

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 (MP) be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DHMH - 16 60M 7/84
(VRA 15, 4)

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

016006 DEC 13 88

FOR 1- STATE REGISTRAR

REG. NO. 88 36962

**1. DECEASED NAME** (TYPE OR PRINT): First: Bruce; Middle: Robert; Last: Singh Bhore

**2a. DATE KNOWN OF DEATH** / ESTIMATED: XX — Month/Day/Year: 11-30-88 — **2b. HOUR**

**3. SEX**: Male

**4. RACE**: Caucasian

**5. DATE OF BIRTH** (Month/Day/Year): June 22,1959

**6. AGE** (IN YEARS LAST BIRTHDAY): 29 YRS. — IF UNDER 1 YR.: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**2c. DATE PRONOUNCED DEAD** (Month/Day/Year): 12-1-88 — **2d. HOUR**: 8:04P M

**7a. BIRTHPLACE** (STATE OR FOREIGN COUNTRY): Massachusetts

**7b. CITIZEN OF WHAT COUNTRY?**: United States

**8. MARRIED** [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

**9. BALTIMORE CITY OR COUNTY OF DEATH**: Montgomery County MD.

**10. CITY OR TOWN OF DEATH**: Gaithersburg

**11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION** (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 18948 Quail Valley Blvd.

**12a. USUAL OCCUPATION** (TYPE OF WORK FOR MOST OF WORKING LIFE): Auto Mechanic

**12b. KIND OF BUSINESS OR INDUSTRY**: Self employed

**USUAL RESIDENCE** (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

**13a. STATE**: Maryland

**13b. COUNTY**: Montgomery

**13c. CITY OR TOWN**: Gaithersburg

**13d. INSIDE CITY LIMITS?** YES [ ] NO [X]

**13e. STREET ADDRESS**: 18948 Quail Valley Blvd./20879

**14. FATHER'S NAME**: First: Joginder; Middle: S.; Last: Bhore

**15. MOTHER'S MAIDEN NAME**: First: Sylvia; Middle: ; Last: Kachoian

**16a. WAS DECEASED EVER IN U.S. ARMED FORCES?** (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

**16b. SOCIAL SECURITY NO.**: 214-70-4491

**17. INFORMANT**: Joginder S. Bhore — **ADDRESS**: 614 Leeanne Avenue, Yuba City, CA 95991

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Gunshot wound of left chest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

**19a. DATE OF OPERATION**:

**19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?**:

**20. AUTOPSY?** YES [XX] NO [ ]

**21a. EXTERNAL CAUSE WAS** UNDERLYING [XX] OR CONTRIBUTING [ ] CAUSE OF DEATH

**21b. TIME OF INJURY** HOUR A.M. P.M. MONTH DAY YEAR: 8:00AM 11-30-88

**21c. HOW INJURY OCCURRED** (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): SElf inflicted

**21d. INJURY OCCURRED** WHILE AT WORK [ ] NOT WHILE AT WORK [XX]

**21e. PLACE OF INJURY** (AT HOME, STREET, FACTORY, FARM, ETC.): home

**21f. LOCATION** STREET / CITY OR TOWN / COUNTY / STATE: 18948 Quail Valley Blvd.,Gaithersburg, Montgomery Co.,MD

22a I certify that I took charge of the remains described above, held on Autopsy [XX] Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [XX], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Charles P. Kokes M.D. — TITLE (SPECIFY): Acting Deputy Chief MEDICAL EXAMINER — DATE SIGNED: 12-2-88

VC EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes,M.D. — ADDRESS: 111 Penn Street,Baltimore,MD 21201

**23a. BURIAL, CREMATION, REMOVAL** (SPECIFY): Cremation

**23b. DATE**: December 5, 1988

**23c. NAME OF CEMETERY OR CREMATORY**: Montgomery Crematorium, Inc.

**23d. LOCATION** CITY OR TOWN / COUNTY / STATE: Bethesda/Montgomery/Maryland

**24. FUNERAL DIRECTOR** NAME / ADDRESS: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc 7557 Wisconsin Ave., Bethesda, Maryland 20814

**25a. DATE REC'D BY REGISTRAR**: DEC 5 '88

**25b. REGISTRAR'S SIGNATURE**: Juha Davidson-Kondaris

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG. NO. 3 3 7 6 9 6 3

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Surapol — MIDDLE: (None) — LAST: Binmahmood

2a. DATE OF DEATH — KNOWN ☐ ESTIMATED XX — MONTH: 12 — DAY: 10 — YEAR: 88 — 2b. HOUR: M

3. SEX: Male — 4. RACE: Thai — 5. DATE OF BIRTH: Oct. 31 1953 — 6. AGE (IN YEARS LAST BIRTHDAY): 35 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN

2c. DATE PRONOUNCED DEAD — MONTH: 12 — DAY: 11 — YEAR: 88 — 2d. HOUR: 7:05 P. M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Thailand

7b. CITIZEN OF WHAT COUNTRY?: Thailand

8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 900 Malcomb Drive

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Waiter

12b. KIND OF BUSINESS OR INDUSTRY: Resturant

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Montgomery — 13c. CITY OR TOWN: Silver Springs — 13d. INSIDE CITY LIMITS? YES XX NO ☐ — 13e. STREET ADDRESS: 900 Malcomb Drive 20901

14. FATHER'S NAME — FIRST: Somboon — MIDDLE: - — LAST: Binmahmood

15. MOTHER'S MAIDEN NAME — FIRST: Somtavil — MIDDLE: - — LAST: Lekcharoen

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): --

16b. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — ADDRESS: Dani Wester/Sister/9133 Sept LA. Silver Springs Md

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Gunshot Wound of Head (Handgun)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? (partial) YES X NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. (est.) MONTH 12 DAY 10 YEAR 1988

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): subject shot himself

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): Home

21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE: 900 Malcomb Drive, Silver Spring, Mont. Co., Md.

22a. I certify that I took charge of the remains described above, held an (partial) Autopsy X, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide XX, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: John E. Smialek — M.D. — TITLE (SPECIFY): Chief MEDICAL EXAMINER — DATE SIGNED: 12-12-88

EXAMINER'S NAME (TYPE OR PRINT): John E. Smialek, M.D. — ADDRESS: 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: Dec. 13, 1988 — 23c. NAME OF CEMETERY OR CREMATORY: Wash National Cem (Islamic) — 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Suitland Maryland

24. FUNERAL DIRECTOR NAME: Robert A. DeVol — ADDRESS: DeVol Funeral Home/2222 Wisc.Ave. Washington D.C.

DEC 15 88 — LOCAL REGISTRAR — LOCAL REGISTRAR'S SIGNATURE: Gloria Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 BP 2 DHMH - 17 (VR A15 ME (3))

17728 DEC 30 88

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36964 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Eva MIDDLE: Minor LAST: Blake | | | 2a. DATE OF DEATH MONTH DAY YEAR: 12-12-88 | 2b. HOUR: 7:20 PM |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: 12 - 13 - 93 | 6. AGE (IN YEARS LAST BIRTHDAY): 94 YRS | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Louisana | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH: Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Georgia | 13b. COUNTY: [illegible] | 13c. CITY OR TOWN: Decatur | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 120 Mimosa Drive 30030 |
| 14. FATHER'S NAME FIRST: Harry MIDDLE: Joseph LAST: Waldo | | | 15. MOTHER'S MAIDEN NAME FIRST: Eva MIDDLE: -- LAST: Jacob | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES): --- | 16b. SOCIAL SECURITY NO.: 428-20-7229 | 17. INFORMANT: Melville E. Blake, Jr. | ADDRESS: 5010 Balt. Ave. Bethesda, MD |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinoma of Ovary with metast — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2yr

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): 

DUE TO, OR AS A CONSEQUENCE OF

(c): 

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/10 19 88 to 12/12 19 88 that (I) (we) last saw the deceased alive on 12/12 19 88 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Myron L Lenkin | DEGREE: MD | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12/13/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): MYRON L. LENKIN | 22e. ADDRESS: 2309 Stonefield Rd Wheaton, MD | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial/Transit | 23b. DATE: 12/13/88 | 23c. NAME OF CEMETERY OR CREMATORY: Odd Fellows Cem. | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Lexington, Miss. | |
| 24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons, Inc. ADDRESS: 5130 Wis. Ave, NW, Wash., D.C. 20016 | DEC 14 88 | DATE RECD. BY REGISTRAR | REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

019355 JAN 17 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 36965

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Edmund | Middle: | Last: Blau | 2a. DATE OF DEATH Month/Day/Year: Dec. 26, 1988 | 2b. HOUR: 9:50AM | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH Month/Day/Year: June 2 1915 | 6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS. | IF UNDER 1 YEAR Months/Days | IF UNDER 24 HRS. Hours/Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH: Kensington | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 3010 Homewood Parkway | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): John Hopkins | 12b. KIND OF BUSINESS OR INDUSTRY: Chemist | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Md. | Mont | Kensington | YES ☒ NO ☐ | 3010 Homewood Parkway |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last | |
|---|---|---|
| Morris / / Blau | Josephine / / Holzman | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WWII | 16b. SOCIAL SECURITY NO.: 130 01 1489 | 17. INFORMANT ADDRESS: 14100 Canterbury Lane Rockville, Md. Henry Blau (Son) |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIOPULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b): METASTATIC ADENOCARCINOMA OF THE COLON

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☑ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY Hour A.M./P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| ☐ | | |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION Street / City or Town / County / State |
|---|---|---|
| WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | | |

22a. I certify that (I) (this hospital) attended the deceased from 11/15/88, 19____, to 12/26/88, 19____, that (I) (we) last saw the deceased alive on 11/15/88, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Barry Raskin, M.D. | ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/26/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Dr. Barry Raskin | 8218 Wisconsin Ave. Beth. Md. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION City or Town / County / State |
|---|---|---|---|
| Cremation | 12/27/88 | Metropolitan Crematory | Alex. Va. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md | DEC 27 '88 | Julia Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

016904 DEC 21 '88
0

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1a FOR STATE REGISTRAR — REG. NO. 88 036966

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: EMMA | Middle: M. | Last: Blythe | 2a. DATE OF DEATH Month: 12 Day: 9 Year: 88 | 2b. HOUR 11:20AM | |
| 3. SEX: Female | 4. RACE: C | 5. DATE OF BIRTH Month: 9 Day: 12 Year: 96 | 6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS. | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Kentucky | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH: Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Newspaper Writer | 12b. KIND OF BUSINESS OR INDUSTRY: News Media | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE: Maryland | 13b. COUNTY: Montgomery | 13c. CITY OR TOWN: Chevy Chase | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 4612 Chevy Chase Blvd. 20815 |

| | | |
|---|---|---|
| 14. FATHER'S NAME: First John / Middle / Last Blythe SR. | 15. MOTHER'S MAIDEN NAME: First Rose / Middle Lucia / Last Allen | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 295-10-7539 | 17. INFORMANT: Ruth Blythe ADDRESS: 4612 Chevy Chase Blvd. Chevy Chase, Maryland 20015 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b): Cerebrovascular Accident
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) this hospital) attended the deceased from 9 19 88 to 12/9 19 88, that (I) (we) last saw the deceased alive on 11/22 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: G Hallick | DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12/9/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): G. HALLICK | 22e. ADDRESS: 11125 Rockville Pike Rockville, Md 20852 | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Dec. 12, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: Cloverport Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Cloverport, Kentucky | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: Ives-Pearson Funeral Homes, Arlington, Virginia | 25a. DATE REC'D. BY REGISTRAR: DEC 20 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

017947 DEC -3 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

S 8 3 6 9 6 7
REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: MOLLIE; MIDDLE: ; LAST: BOGEN | | | | 2a. DATE OF DEATH MONTH DAY YEAR: 12-27-88 | 2b. HOUR: 11:54 PM |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: 8-17-06 | 6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): POLAND | 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD. | | |
| 10. CITY OR TOWN OF DEATH: Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Montgomery | 13c. CITY OR TOWN: Rockville | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 12630 Viers Mill Road, #116 (20853) | |
| 14. FATHER'S NAME FIRST: Benjamin; MIDDLE: ; LAST: Littman | | | 15. MOTHER'S MAIDEN NAME FIRST: Sarah; MIDDLE: ; LAST: Dolinsky | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES): -------- | 16b. SOCIAL SECURITY NO.: 055-28-2224 | 17. INFORMANT: Florence Hollin; Daughter; | ADDRESS: Rockville, Md. 20853; 5 Boxelder Court; | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiogenic Shock — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 hr
DUE TO, OR AS A CONSEQUENCE OF (b): Acute Myocardial Infarction — 3 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/26 19 88, to 12/27 19 88, that (I) (we) last saw the deceased alive on 12-27 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Alan Kermaier, MD — DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/30/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ALAN I. KERMAIER, MD — 22e. ADDRESS: 10313 GEORGIA AVE. SS. MD 20902

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/30/88 | 23c. NAME OF CEMETERY OR CREMATORY: Beth David Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Elmont, New York |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: DANZANSKY-GOLDBERG MEMORIAL CHAPELS; 1170 Rockville Pike; Rockville, Md. 20852 | | 25a. DATE REC'D. BY REGISTRAR: DEC 30 1988 | 25b. REGISTRAR'S SIGNATURE: |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

16109 DEC 14 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

REG. NO. 88 036963

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: RUZICA | MIDDLE: M. | LAST: BOGICEVIC | 2a. DATE OF DEATH MONTH DAY YEAR: 12-07-88 | 2b. HOUR: 8:35 PM | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: May 29 1908 | 6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Yugoslovia | 7b. CITIZEN OF WHAT COUNTRY?: Permanent resident | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH: Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Cook | 12b. KIND OF BUSINESS OR INDUSTRY: Bavarian Restaurant | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Silver Spring | YES ☒ NO ☐ | 8484 16th. St., 20910 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Isa / / Bogojev | Marija / / Sabovljovic |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| N/A | N/A | 578-76-9464 | Slobodan Bogicevic-son-(same as e) |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Massive cerebrovascular accident | immediate |
| DUE TO, OR AS A CONSEQUENCE OF (b) | arteriosclerotic vascular disease | 10 years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): congestive heart failure

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from Jan 11 19 85 to Dec. 7 19 88, that (I) (we) last saw the deceased alive on Dec. 7 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| G Peter Pushkas | MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | 7:35 AM Dec. 8, 1988 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| G Peter Pushkas | 11510 Old Georgetown Rd. Rockville |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12-12-1988 | Rock Creek Cemetery | Washington, DC |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 26b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, MD. | DEC 13 1988 | Julia Davidson-Randall |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 369697

018479 JAN-9 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: HJordis | MIDDLE: M. | LAST: Bohlin | 2a. DATE OF DEATH MONTH DAY YEAR: 12 15 88 | 2b. HOUR: 1714 M | |
| 3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: December 8, 1903 | 6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Norway | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH: Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Hospita | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Gaithersburg | YES ☒ NO ☐ | 409 Muddy Branch Road, #201/ 20878 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | |
|---|---|---|
| Carl / / Lind | Emily / / not available | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 325-28-9361 | Ann B. Tremaine | 10509 MacArthur Blvd. Potomac, Maryland 20854 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septic shock — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
DUE TO, OR AS A CONSEQUENCE OF (b): Renal failure
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Congestive heart failure

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 12/13 19 88 to 12/15 19 88, that (I) (~~we~~) last saw the deceased alive on 12/13 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Robert Millman | ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/15/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Robert Millman, MD | 921 Medical Center Dr #103 Rockville, Md 20850 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | December 16, 1988 | Montgomery Crematorium, Inc. | Bethesda/Montgomery/Maryland |

24. FUNERAL DIRECTOR NAME: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. ADDRESS: 7557 Wisconsin Avenue, Bethesda, Maryland 20814
DATE RECD. BY REGISTRAR: DEC 1988 REGISTRAR'S SIGNATURE: Gina Davidson-Pondelik

BP 105

DHMH - 16 50M 1/81 (VRA 15, 4)

0 1 6 4 1 1 DEC 1500

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

FOR STATE REGISTRAR — 88 REG. NO. 36970

1. DECEASED NAME (TYPE OR PRINT): Harwood C. Bowman Jr.

2a. DATE OF DEATH: 12 07 88 — 2b. HOUR: 9:55 PM

3. SEX: male

4. RACE: Cauc.

5. DATE OF BIRTH: 12 20 19

6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Alabama

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: OLNEY

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): BROOKE GROVE

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CLERGYMAN.

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD — 13b. COUNTY: MONTGOMERY — 13c. CITY OR TOWN: SILVER SPRING — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS / ZIP CODE: 3106 Beckenham Ct. 20906

14. FATHER'S NAME: Harwood C. Bowman Sr.

15. MOTHER'S MAIDEN NAME: Mary Taylor Tuttle

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 579 50 7711

17. INFORMANT ADDRESS: Marion Bowman (Wife) Same as 13E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): PNEUMONIA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS

DUE TO, OR AS A CONSEQUENCE OF (b): ASPIRATION

DUE TO, OR AS A CONSEQUENCE OF (c): ADVANCED CHRONIC LYMPHOCYTIC LEUKEMIA — 17 YEARS

912

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/17, 19 88, to 12/7, 19 88, that (I) (we) last saw the deceased alive on 12/2, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robert Fields MD — DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12/7/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ROBERT P FIELDS, MD

22e. ADDRESS: 18111 PRINCE PHILIP DR, T-12; OLNEY, MD 20832

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 12/10/88

23c. NAME OF CEMETERY OR CREMATORY: St.Mark's Cemetery

23d. LOCATION: CITY OR TOWN S.S. — COUNTY Mont. — STATE Md.

24. FUNERAL DIRECTOR: Hines/Rinaldi 11800 New Hamp.Ave.S.S.Md.

DATE REC'D. BY REGISTRAR: DEC 13 1988

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rudasa

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 31 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

016551 DEC 19 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36971
REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: James | Middle: HARTMAN | Last: Bowen | 2a. DATE OF DEATH Month Day Year: 12 06 88 | 2b. HOUR: 102 Am | |
| 3. SEX: male | 4. RACE: White | 5. DATE OF BIRTH Month Day Year: March 13, 1922 | 6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS. | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH: Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SHADY GROVE ADVENTIST | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired | 12b. KIND OF BUSINESS OR INDUSTRY: Dept. Army Communications | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
|---|---|---|---|---|---|
| Maryland | Montgomery | Rockville | YES [X] NO [ ] | 12614 Turkey Branch Parkway | 20853 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last | |
|---|---|---|
| John / Davis / Bowen | Gertrude / Purcell | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | |
|---|---|---|---|---|
| Yes | 1942-1966 | 578-20-5732 | Jamestown, N.D. | Bonnie Sue Bowen (daughter) 2111 3rd St. N.E. |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | VENTRICULAR TACHYCARDIA | 1/2 HOUR |
| DUE TO, OR AS A CONSEQUENCE OF (b) | MYOCARDIAL INFARCTION | 1 WEEK |
| DUE TO, OR AS A CONSEQUENCE OF (c) | CORONARY THROMBOSIS | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: CARCINOMA COLON. PEPTIC ULCER.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 11 30 19 88 to 12 5 19 88 that (I) (we) last saw the deceased alive on 12 5 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 12/6/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): GREGORIO KAU

22e. ADDRESS: 15225 SHADY GROVE RD. ROCKVILLE MD

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | 12/8/88 | Mt. Comfort Crematory | Alexandria, Virginia |

24. FUNERAL DIRECTOR (NAME / ADDRESS): Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852

25a. DATE REC'D. BY REGISTRAR: DEC 7 '88

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rondelle

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 10+1

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 3 6 9 7 2

0165 DEC 1988

1. DECEASED NAME (TYPE OR PRINT): FIRST Lucille MIDDLE C. LAST Boyd

2a. DATE KNOWN OF DEATH / ESTIMATED: MONTH Dec DAY 4 YEAR 1988

2b. HOUR 1200 M

3. SEX: F

4. RACE: W

5. DATE OF BIRTH: MONTH JUNE DAY 2 YEAR 1894

6. AGE (IN YEARS LAST BIRTHDAY): 94 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH Dec DAY 4 YEAR 1988

2d. HOUR 1200 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WEST VIRGINIA

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD

10. CITY OR TOWN OF DEATH: St. Spg

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 14625 DEERHURST LANE

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CHIROPRACTOR

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md

13b. COUNTY: Mont

13c. CITY OR TOWN: St. Spg.

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 14625 DEERHURST LANE 20906

14. FATHER'S NAME: FIRST JOHN MIDDLE E. LAST MULVANEY

15. MOTHER'S MAIDEN NAME: FIRST ELLEN MIDDLE LAST WHITE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 579-60-0382

17. INFORMANT: SON RON CALLAHAN ADDRESS 3006 WISEMAN ROAD WHEATON, MD 20902

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Inf

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: John S Rogers M.D. TITLE (SPECIFY): Dop MEDICAL EXAMINER DATE SIGNED: Dec 5, 1988

EXAMINER'S NAME (TYPE OR PRINT): JOHN S. ROGERS, M.D. ADDRESS: 1919 SEMINARY ROAD SILVER SPRING, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: DEC 8, 1988

23c. NAME OF CEMETERY OR CREMATORY: HOLY CROSS CEMETERY

23d. LOCATION CITY OR TOWN: CLARKSBURG COUNTY STATE: WEST VA

24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901

25a. DATE REC'D BY REGISTRAR: DEC 6 '88

25b. REGISTRAR'S SIGNATURE: Gwendolyn Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

19356 JAN 17 89

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 036973

1. DECEASED NAME (TYPE OR PRINT): FIRST Ann MIDDLE M. LAST Boysen
2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ MONTH Dec DAY 25 YEAR 19 88
2b. HOUR 11:22 A.M.
3. SEX: Female
4. RACE: Caucasian
5. DATE OF BIRTH: MONTH June DAY 15 YEAR 1914
6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.
2c. DATE PRONOUNCED DEAD: MONTH Dec DAY 26 YEAR 19 88
2d. HOUR 11:47 A.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania
7b. CITIZEN OF WHAT COUNTRY? United States
8. MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD
10. CITY OR TOWN OF DEATH: Silver Spring
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 15115 Interlachen Road, #624
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker
12b. KIND OF BUSINESS OR INDUSTRY: Own Home
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Silver Spring
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: 15115 Interlachen Road, #624 Zip: 20906
14. FATHER'S NAME: FIRST Martin MIDDLE LAST Golden
15. MOTHER'S MAIDEN NAME: FIRST Not available MIDDLE LAST Roland
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): -
16b. SOCIAL SECURITY NO.: 335-03-3741
17. INFORMANT ADDRESS: Margaret Maloney Barnhill, Wife, 14805 Carrolton Road, Rockville, MD. 20853

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial DK
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: John S. Rogers M.D. TITLE (SPECIFY): Dep. MEDICAL EXAMINER DATE SIGNED: Dec 28 1988
EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers, M.D. ADDRESS: 1919 Seminary Road Silver Spring, Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: December 29, 1988
23c. NAME OF CEMETERY OR CREMATORY: Immaculate Conception Cemetery
23d. LOCATION CITY OR TOWN: Montclair COUNTY STATE: New Jersey
24. FUNERAL DIRECTOR NAME: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. ADDRESS: 7557 Wiscinsin Avenue, Bethesda, Maryland
25a. DATE REC'D. BY REGISTRAR: DEC 28 '88
25b. REGISTRAR'S SIGNATURE: Lidia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP 10
DHMH - 17 (VR A15 ME (5))

017404 DEC 28 88

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

88 REG. NO. 36974

1a. DECEASED NAME (TYPE OR PRINT): FIRST Samuel MIDDLE Homer LAST BRANDT

2a. DATE OF DEATH: MONTH DAY YEAR December 21, 1988

2b. HOUR 11:50 PM

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: MONTH DAY YEAR Feb. 23, 1914

6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania

7b. CITIZEN OF WHAT COUNTRY? American

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Germantown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 23224 Ridge Road

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mechanic

12b. KIND OF BUSINESS OR INDUSTRY: Pump

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montg.

13c. CITY OR TOWN: Germantown

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS / ZIP CODE: 23224 Ridge Road 20874

14. FATHER'S NAME: FIRST Christian MIDDLE Witmer LAST Brandt

15. MOTHER'S MAIDEN NAME: FIRST Edna MIDDLE M LAST Groff

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): 1941-45

16b. SOCIAL SECURITY NO.: 181-05-7157

17. INFORMANT: Mary Shank ADDRESS: 8440 Palmer Road Middletown, Maryland

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Metastatic Colon Cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 9 months

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from March 23, 1988, to Dec 22, 1988, that (I) (we) last saw the deceased alive on Dec 19, 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] MD

DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 12/22/1988

22d. PHYSICIAN'S NAME (TYPE OR PRINT): James A. Brown

22e. ADDRESS: 14800 Physicians Lane, Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 12/26/88

23c. NAME OF CEMETERY OR CREMATORY: Resthaven Mem. Pk.

23d. LOCATION: CITY OR TOWN Frederick, COUNTY Maryland STATE

24. FUNERAL DIRECTOR: NAME, ADDRESS: Olin L. Molesworth, P.A., Damascus, Md.

25a. DATE REC'D. BY REGISTRAR: DEC 27 1988

25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 10 60M 7/84 (VRA 15, 4)

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 36975

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

01847 JAN -9 89

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: AIDA; MIDDLE: ; LAST: ELIZONDO BRAY | | | | 2a. DATE OF DEATH MONTH DAY YEAR: 12-11-88 | 2b. HOUR: 11 30 PM |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR: FEB. 3 1918 | 6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MEXICO | 7b. CITIZEN OF WHAT COUNTRY?: LEGAL RESIDENT U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH: Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hosp. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Sec't. | 12b. KIND OF BUSINESS OR INDUSTRY: World Bank | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: — | 13b. COUNTY: — | 13c. CITY OR TOWN: WASH. D.C. | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 2000 Conn. Ave. NW | |
| 14. FATHER'S NAME FIRST: ANTONIO; MIDDLE: M.; LAST: Elizondo | | 15. MOTHER'S MAIDEN NAME FIRST: BRAULIA; MIDDLE: ; LAST: BRAY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | 16b. (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 527520737 | 17. INFORMANT: MARIA L. E RUBIO | ADDRESS: 726 15th ST. Douglas, Ariz. | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiorespiratory arrest | minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Large cell Lymphoma | 6 months |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Pulmonary embolism; lupus; Ruptured Spleen

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from November 24, 19 88, to December 9, 19 88, that (I) (we) last saw the deceased alive on December 9, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE | DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12/12/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOSE A QUIROS | 22e. ADDRESS: 4343 MONTGOMERY AV Bethesda MD 20814 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: DEC. 15, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEM | 23d. LOCATION CITY OR TOWN: Silver Spring | COUNTY: MD | STATE |
| 24. FUNERAL DIRECTOR NAME: John F. Devol ADDRESS: DEVOL FUNERAL HOME WASH. D.C. | | 25a. DATE REC'D. BY REGISTRAR: DEC 15 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

BP 1-82
DHMH 16 SDM 1-81 (VRA 15, 4)

016300 DEC 15 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO 88 36976

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be printed separately for hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: JUNIE MIDDLE: Catherine LAST: BREEDEN | | | | 2a. DATE OF DEATH MONTH DAY YEAR: Dec 5 1988 | 2b. HOUR: 7 15 PM |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: 6 28 07 | 6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS. | IF UNDER 1 YEAR MONTHS: | DAYS: | IF UNDER 24 HRS. HOURS: | MIN.: |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH: Wheaton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Randolph Hill Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Virginia | 13b. COUNTY: Page Co. | 13c. CITY OR TOWN: Stanley | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET ADDRESS / ZIP CODE: RFD 2 22851 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST: William Thomas | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Virginia Lam | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): N/A | 16b. SOCIAL SECURITY NO.: 223-18-8567B | 17. INFORMANT: Bonnie Housden/11104 Troy Road, Rockville, | ADDRESS: Maryland 20852 | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Instant

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic heart disease — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Atrial fibrillation

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [XX] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) this hospital) attended the deceased from 6/15, 19 88, to 12/5, 19 88, that (I (we) last saw the deceased alive on 12/5, 19 88, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did (did not) view the body after death.

22b. SIGNATURE: Martin Shagel — DEGREE: M.D. — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 12/5/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MARTIN C. SHAGEL — 22e. ADDRESS: 3720 FARRAGUT AVE. KENSINGTON, MD - 20895

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12-8-1988 | 23c. NAME OF CEMETERY OR CREMATORY: Thomas Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Bradley Page Virginia |

24. FUNERAL DIRECTOR NAME: Bradley Funeral Home — ADDRESS: 187 East Main Street, Luray, Virginia 22835

25a. DATE REC'D. BY REGISTRAR: DEC 14 1988 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rundell

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 036973

01847 JAN - 3 89

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Carol | M. | Brooks | December 17, 1988 | 3:15A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Female | Caucasian | June 17, 1933 | 55 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Washington, D.C. | United States | | Montgomery County, MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Rockville | 11410 Strand Drive, #111 | Homemaker | Own Home |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Rockville | YES ☐ NO XX | 11410 Strand Drive, #111 /20852 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Francis | A. | Murray,Sr. | Edith | | Everett |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | - | 231-46-6198 | Mrs. Robin L. Rooney, Daughter, 19932 Sweetgum Circle, #11, Germantown, MD. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic Breast Cancer
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| ☐ | | |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | | |

22a. I certify that (I) (this hospital) attended the deceased from - 19 86, to December 12, 1988, that (I) ~~XX~~ last saw the deceased alive on December 12 19 88, and that in (my) XX opinion death occurred on the date and hour and from the causes stated above, (I) ~~XX~~ (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN | 22c. DATE SIGNED |
|---|---|---|---|
| A.R. Greenspan | MD | ☐ / ☐ / ✓ | 12/19/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Andrew R. Greenspan, M.D. | 3800 Reservoir Road, N.W. Washington, D.C. 20007 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | December 20, 1988 | Rock Creek Cemetery | Washington, D.C. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland | DEC 20 '88 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 40

DHMH - 16 50M 1/81 (VRA 15, 4)

Q16002 Dec 13

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 36979

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other [illegible], the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Clay | MIDDLE: Evans | LAST: Brooks, JR. | 2a. DATE OF DEATH MONTH DAY YEAR: December 1, 1988 | 2b. HOUR: 6:30 PM | |
| 3. SEX: MALE | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: May 20, 1924 | 6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C. | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD. | | |
| 10. CITY OR TOWN OF DEATH: Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 11410 Strand Drive, #111 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Principal | 12b. KIND OF BUSINESS OR INDUSTRY: Education | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Montgomery | 13c. CITY OR TOWN: Rockville | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET ADDRESS: 11410 Strand Drive #111/20852 | |
| 14. FATHER'S NAME FIRST: Clay | MIDDLE: E. | LAST: Brooks, Sr. | 15. MOTHER'S MAIDEN NAME FIRST: Ethlyn | MIDDLE: | LAST: Higgins |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes | (IF YES, GIVE WAR OR DATES): WWII | 16b. SOCIAL SECURITY NO.: 577 28 7503 | 17. INFORMANT: (Son) Kevin F. Brooks, | ADDRESS: 9917 Thornwood Rd. Kensington, Md. 20895 | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | RESPIRATORY FAILURE | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | LUNG CANCER | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [XX] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from July 19 83 to December 1 19 88, that (I) (we) last saw the deceased alive on November 19 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Edward A. Sausville | DEGREE: MD | ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED: Dec. 2, 1988 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Edward A. Sausville | 22e. ADDRESS: Div Med Oncol Georgetown Univ Med Ctr | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: December 05, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery | 23d. LOCATION CITY OR TOWN: Washington, D.C. | COUNTY / STATE |
| 24. FUNERAL DIRECTOR NAME: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland | 25a. DATE REC'D. BY REGISTRAR: DEC 5 '88 | 25b. REGISTRAR'S SIGNATURE: John Davidson-Mendelle | | |

016409 DEC 15 88 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 369801

| 1. DECEASED NAME (TYPE OR PRINT) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Robert | T. | Brouillette | Dec. 9 1988 | 12:30 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH Month Day Year | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
|---|---|---|---|---|---|
| Male | White | Mar. 29 1919 | 69 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Massachusetts | USA | MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | Montgomery MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Bethesda | Suburban Hospital | Retired | Reuben Donnely Corp. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | MOntgomery | Silver Spring | YES ☒ NO ☐ | 15311 Beaver Brook Ct. Apt. 2-F 20906 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last |
|---|---|
| EDward / / Brouillette | Clyde / / Tate |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| Yes | WW11 | 030-10-9791 | CAtherine C. Brouillette-wife-(same as 13e) |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | acute pulmonary failure with pseudomonas infection | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | chronic obstructive pulmonary disease | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chol cystectomy with postoperative complications

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | cholecystitis and cholelithiasis | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from March 19 87 to 12/8 19 88, that (I) (we) last saw the deceased alive on 12/8 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Sidney Malawer MD. | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐ | 12/9/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Sidney Malawer, MD | 10215 Fernwood Rd. Bethesda, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12-13-1988 | Arlington National | Arlington Virginia |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, MD. | DEC 13 1988 | Julia Davidson-Landeau |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

017156 DEC 27 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 36981

1. DECEASED NAME (TYPE OR PRINT) FIRST: Louis MIDDLE: BROWDY LAST:
2a. DATE OF DEATH MONTH DAY YEAR: 12-20-88
2b. HOUR: 8:30 a.m.
3. SEX: Male
4. RACE: CAUC.
5. DATE OF BIRTH MONTH DAY YEAR: 6 29 93
6. AGE (IN YEARS LAST BIRTHDAY): 95 YRS. IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): OHIO
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Bethesda
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FERNWOOD Nursing Home
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Editor
12b. KIND OF BUSINESS OR INDUSTRY: Amerika Magazine

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Bethesda
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 5810 Ipswich Road (20814)

14. FATHER'S NAME FIRST Julius MIDDLE LAST Browdy
15. MOTHER'S MAIDEN NAME FIRST Sara MIDDLE Deborah LAST Bernstein
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WWI
16b. SOCIAL SECURITY NO.: 577-60-4885
17. INFORMANT ADDRESS: William Geiger; Executor; 5810 Ipswich Road; Bethesda, Md. 20814

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): gastric carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): cerebrovascular accident

19a. DATE OF OPERATION: N/A
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: N/A
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19: N/A
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2): N/A
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐: N/A
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.): N/A
21f. LOCATION STREET: N/A CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/19 19 88 to 12/20 19 88, that (I) (we) last saw the deceased alive on 12/17 19 88, and that on (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.
22b. SIGNATURE: Kathryn S. Kirwin DEGREE: M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/20/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): KATHRYN S. KIRWIN MD
22e. ADDRESS: #606 10400 Connecticut Ave Kensington Md 20895

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 12/28/88
23c. NAME OF CEMETERY OR CREMATORY: Temple On The Heights
23d. LOCATION CITY OR TOWN: Cleveland, Ohio COUNTY STATE

24. FUNERAL DIRECTOR (NAME) DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS: 1170 Rockville Pike; Rockville, Md. 20852
25a. DATE REC'D. BY REGISTRAR: DEC 23 1988
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16.50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

88 REG. NO. 36982

0184 JAN - 9 89

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Alberta; MIDDLE: E; LAST: Brower
2a. DATE OF DEATH — MONTH DAY YEAR: 12 16 88
2b. HOUR: 2315 M
3. SEX: FEMALE
4. RACE: CAUC.
5. DATE OF BIRTH — MONTH DAY YEAR: JULY 16 1898
6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: TAKOMA PARK
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY: MONTGOMERY
13c. CITY OR TOWN: SILVER SPRING
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS / ZIP CODE: 1013 ROSWELL DR. 20901

14. FATHER'S NAME — FIRST: JOHN; MIDDLE; LAST: JONES
15. MOTHER'S MAIDEN NAME — FIRST: ANNIE; MIDDLE; LAST: BRODE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
16a. (IF YES, GIVE WAR OR DATES): NONE
16b. SOCIAL SECURITY NO.: 228-92-0125
17. INFORMANT — ADDRESS: WARD L. BROWER (SON) SAME AS 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b): ACUTE BRAIN INFARCTION
DUE TO, OR AS A CONSEQUENCE OF (c): HYPERTENSION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/15/88 to 12/16/88, that (I) (we) last saw the deceased alive on 12/16/88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/17/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): E. SUDHAKAR
22e. ADDRESS: 7610 CARROLL AVE #230 TAKOMA PARK, MD 20912

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: DEC. 20 1988
23c. NAME OF CEMETERY OR CREMATORY: AUGUSTA MEM. PARK
23d. LOCATION — CITY OR TOWN: WAYNESBORO; COUNTY: AUGUSTA; STATE: VA.

24. FUNERAL DIRECTOR: FRANCIS J. COLLINS JR.
ADDRESS: 500 UNIVERSITY BLVD. W. SILVER SPRING, MD. 20901

25a. DATE RECEIVED BY REGISTRAR: DEC 29 1988
25b. REGISTRAR'S SIGNATURE: Githa Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 6

RDHMH - 16 60M 7/84 (VRA 15, 4)

015969 DEC 13 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR Iris Edrina Brown

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

REG. NO 88 36983

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: IRIS | MIDDLE: EDRINA | LAST: Brown | 2a. DATE OF DEATH MONTH DAY YEAR: 12/6/88 | 2b. HOUR: 6P M | | |
| 3. SEX: FEMALE | 4. RACE: Black | 5. DATE OF BIRTH MONTH DAY YEAR: 11/06/06 | 6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Jamaica St. Elizabeth, | 7b. CITIZEN OF WHAT COUNTRY?: Jamaica | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH: SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: at home | | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Germantown | YES ☒ NO ☐ | 16000-Germantown Road 20874 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| George | - | Solomon | Mahalia | - | Mattis |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| no | | 220-80-2721 | Ann F. Phillips (Daughter) Same as #13 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 WEEKS
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (~~this hospital~~) attended the deceased from 26 NOV 19 88 to 6 DEC 19 88, that (I) (~~saw~~) last saw the deceased alive on 6 DEC 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~ did not) view the body after death.

22b. SIGNATURE [signature] DEGREE MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 7 DEC 88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): WALTER E. GOOCH MD

22e. ADDRESS: 2309 SHAKEFIELD RD WHEATON MD 20902

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | Dec. 8, 1988 | Lee's Crematory | Washington, District of Columbi |

24. FUNERAL DIRECTOR NAME AND ADDRESS: J. Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002

25a. DATE REC'D. BY REGISTRAR: DEC 12 1988

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landeau

7502 DEC 28 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR CLIFFORD C. BROYLES

REG. NO. 88 369831

1. DECEASED NAME (TYPE OR PRINT) First: Clifford Middle: C. Last: Broyles

2a. DATE OF DEATH Month: 12 Day: 19 Year: 88

2b. HOUR 8:45 AM

3. SEX: MALE

4. RACE: WHITE

5. DATE OF BIRTH Month: MAY 10, Day: 1908 Year:

6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): TENN.

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: BURTONSVILLE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 3232 SPENCERVILLE ROAD

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): LANDSCAPER

12b. KIND OF BUSINESS OR INDUSTRY: LANDSCAPING

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD. 13b. COUNTY: MONTGOMERY 13c. CITY OR TOWN: BURTONSVILLE 13d. INSIDE CITY LIMITS? YES [ ] NO [X] 13e. STREET ADDRESS / ZIP CODE: 3232 SPENCERVILLE RD. 20866

14. FATHER'S NAME First: JACOB Middle: - Last: BROYLES

15. MOTHER'S MAIDEN NAME First: NORA Middle: - Last: CRUM

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 218-12-7656

17. INFORMANT: Mabel Broyles ADDRESS: Same as # 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrhythmia, Suspected
DUE TO, OR AS A CONSEQUENCE OF (b): Atherosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/12, 19 87, to 12/18, 19 88, that (I) (we) last saw the deceased alive on 12/12, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John G. Lodwell MD DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED 12/19/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): John G. Lodwell

22e. ADDRESS 2901 Olney-Sandy Spring Rd Olney, MD 20832

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Dec. 22, 1988

23c. NAME OF CEMETERY OR CREMATORY: Union Cemetery

23d. LOCATION CITY OR TOWN: Burtonsville COUNTY: Mont. STATE: Md.

24. FUNERAL DIRECTOR NAME: Muriel H. Barber ADDRESS: Laytonsville, Md. 20879

25a. DATE REC'D. BY REGISTRAR: DEC 22 1988

25b. REGISTRAR'S SIGNATURE: Julia Davidson Rudacille

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

15 BP

DHMH - 16 60M 7/84
(VRA 15, 4)

016302 DEC 15 88 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36985 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 16 50M 1/81 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Dorothy | MIDDLE | LAST: BRUMM | 2a. DATE OF DEATH MONTH: Dec | DAY: 3 | YEAR: 88 |
| 2b. HOUR: 9:35 PM | | | | | |
| 3. SEX: F | 4. RACE: Cauc | 5. DATE OF BIRTH MONTH: Jan DAY: 27 YEAR: 1910 | 6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. | IF UNDER 1 YEAR MONTHS: | DAYS: |
| IF UNDER 24 HRS HOURS: | MIN.: | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH: Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Artist | 12b. KIND OF BUSINESS OR INDUSTRY: Self Employed | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE: Maryland | 13b. COUNTY: Montgomery | 13c. CITY OR TOWN: Bethesda | 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ | 13e. STREET ADDRESS: 6013 Walhonding Road 20816 | |
| 14. FATHER'S NAME FIRST: unknown | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST: Unknown | MIDDLE | LAST |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): ND | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 551-14-7601 | 17. INFORMANT: John Brumm (Husband) | ADDRESS: 6013 Walhonding Rd Bethesda MD | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO, OR AS A CONSEQUENCE OF
(b): Chronic obstructive pulmonary Disease
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 11-29, 19 88, to 12-3, 19 88, that (I) (we) last saw the deceased alive on 12/3, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Stephen L Schechter — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12-4-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Stephen L. Schechter MD — 22e. ADDRESS: 8218 Wisconsin Ave 014, Bethesda Md 20814

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal | 23b. DATE: 12-5-88 | 23c. NAME OF CEMETERY OR CREMATORY: Georgetown Med. School | 23d. LOCATION CITY OR TOWN: Washington | COUNTY | STATE: DC |

24. FUNERAL DIRECTOR NAME: Robert G. Moxon — ADDRESS: 1661 Good Hope Road, SE — 25a. DATE REC'D. BY REGISTRAR: DEC 14 1988 — 25b. REGISTRAR'S SIGNATURE: Julia Gardner-Randall

.8162 JAN 5 89

FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

REG. NO. 88 036986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Gladys | MIDDLE: - | LAST: Burger | 2a. DATE OF DEATH MONTH DAY YEAR: December 28, 1988 | 2b. HOUR: 1:08 PM |
| 3. SEX: Female | 4. RACE: W | 5. DATE OF BIRTH MONTH DAY YEAR: FEB. 18 24 | 6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS | IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH: Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): NURSE | 12b. KIND OF BUSINESS OR INDUSTRY: NURSING | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md | 13b. COUNTY: Montgomery | 13c. CITY OR TOWN: Sandy Spring | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET ADDRESS: 17310 Quaker Lane C-25 20860 |
| 14. FATHER'S NAME FIRST: HARRY MIDDLE: - LAST: WEINSTEIN | | 15. MOTHER'S MAIDEN NAME FIRST: FREDA MIDDLE: - LAST: KIRSCHBAUM | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A | 16b. IF YES, GIVE WAR OR DATES | 16b. SOCIAL SECURITY NO.: 109 14 4276 | 17. INFORMANT: MERLE L. BURGER | ADDRESS: SAME AS #13 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiovascular collapse — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2days

DUE TO, OR AS A CONSEQUENCE OF (b): Sepsis — 2day

DUE TO, OR AS A CONSEQUENCE OF (c): Perforated viscous — 2days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: 12/26/88 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Perforated viscous | 20a. AUTOPSY? YES ☒ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/26/88, 19____, to 12/28/88, 19____, that (I) (we) last saw the deceased alive on 12/28/88, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: Arthur F. Woodward Jr | DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12/28/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Arthur F Woodward Jr Frank Mayo, M.D. | 22e. ADDRESS: 18111 Prince Philip Dr Olney md | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION | 23b. DATE: DEC.30,1988 | 23c. NAME OF CEMETERY OR CREMATORY: BALT.WASH.CREMATORY | 23d. LOCATION CITY OR TOWN: LAUREL | COUNTY: P.GEORGE STATE: MD. |
| 24. FUNERAL DIRECTOR NAME: MURIEL H. BARBER | ADDRESS: LAYTONSVILLE, MD. 20879 | 25a. DATE REC'D. BY REGISTRAR: JAN 3 1989 | 25b. REGISTRAR'S SIGNATURE: Zitha Davidson-Rodgers | |

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

016303 DEC 15 88

FOR STATE REGISTRAR UNK.#88-153

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 6 9 8 7

1. DECEASED NAME (TYPE OR PRINT): FIRST Samuel MIDDLE Henry LAST Cahill

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED XX — MONTH 12-2 DAY YEAR 19 88 — 2b. HOUR M

3. SEX: MALE — 4. RACE: Black — 5. DATE OF BIRTH: MONTH MAY DAY 21 YEAR 1955 — 6. AGE (IN YEARS LAST BIRTHDAY): 33 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 12-3 DAY YEAR 19 88 — 2d. HOUR 11:25 a.m.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VIRGINIA — 7b. CITIZEN OF WHAT COUNTRY? USA — 8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.

10. CITY OR TOWN OF DEATH: Silver Spring — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 7990 Georgia Ave., Room 419 — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Food Service — 12b. KIND OF BUSINESS OR INDUSTRY: Restaurant

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY — 13c. CITY OR TOWN: Baltimore — 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ — 13e. STREET ADDRESS: Unknown 9999

14. FATHER'S NAME: FIRST Samuel MIDDLE Henry LAST Cahill SR.

15. MOTHER'S MAIDEN NAME: FIRST Elizabeth MIDDLE LAST Milner

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 213-76-7975

17. INFORMANT: Agnes Hairston — ADDRESS: Martinsville VA 24112

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Drug Abuse
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY (est.) HOUR A.M. P.M. 12-2 MONTH DAY YEAR 1988 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): subject used drugs

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): motel — 21f. LOCATION STREET: 7990 Georgia Ave., CITY OR TOWN: Silver Spring, COUNTY: Montgomery Co., STATE: Md.

22a. I certify that I took charge of the remains described above, held an Autopsy XX Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner XX

ACTUAL SIGNATURE: [signature] M.D. — TITLE (SPECIFY): Chief MEDICAL EXAMINER — DATE SIGNED 12-4-88

EXAMINER'S NAME (TYPE OR PRINT): John E. Smialek, M.D. — ADDRESS: 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 12/10/88 — 23c. NAME OF CEMETERY OR CREMATORY: Carver Mem. Gardens — 23d. LOCATION CITY OR TOWN: Martinsville County: Henry Co. STATE: Va.

24. FUNERAL DIRECTOR NAME: Marshall W. Jones, Jr. ADDRESS: 401 Edmondson Ave 21229

25a. DATE REC'D. BY REGISTRAR: DEC 9 1988 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M — BP ____ — DHMH - 17 (VR A15 ME (5))

017730 DEC 30 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1a FOR STATE REGISTRAR

REG. NO 88 036983

1. DECEASED NAME (TYPE OR PRINT) — FIRST George (GeorGE) MIDDLE James LAST Calomiris (CALOMIRIS)

2a. DATE OF DEATH — MONTH 12 DAY 12 YEAR 88

2b. HOUR 2153 M

3. SEX: Male M

4. RACE: White

5. DATE OF BIRTH — MONTH Mar. DAY 25, YEAR 1938

6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): DC

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Realtor

12b. KIND OF BUSINESS OR INDUSTRY: Real Estate

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD — 13b. COUNTY: Mont. — 13c. CITY OR TOWN: Bethesda — 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS: 8516 Thornden Terrace 20817

14. FATHER'S NAME — FIRST James MIDDLE G. LAST Calomiris

15. MOTHER'S MAIDEN NAME — FIRST Cardine MIDDLE E. LAST Beal

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): Peacetime

16b. SOCIAL SECURITY NO.: 577-52-5145

17. INFORMANT ADDRESS: Penelope C. Calomiris Same as item # 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 hrs
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease — 12 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — 20a. AUTOPSY? YES [ ] NO [X] — 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ] — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from [illegible] 19 78, to 12/12 19 88, that (I) (we) last saw the deceased alive on 12/12 19 88, and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 12/13/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Gary P Fisher MD — 22e. ADDRESS: 5530 Wisconsin Ave

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 12/15/88 — 23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem. — 23d. LOCATION CITY OR TOWN: Silver Spring, COUNTY: MD STATE

24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons, Inc. — ADDRESS: 5130 WI Ave. NW Wash., DC 20016

25a. DATE RECD. BY REGISTRAR: DEC 14 '88 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16-50M 1/81 (VRA 15, 4)

0177 DEC 30 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 369889 REG. NO

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Estelle Middle: H. Last: Cameron | | | | 2a. DATE OF DEATH Month Day Year: December 12, 1988 | 2b. HOUR: 4:35 AM |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH Month Day Year: Mar. 3, 1901 | 6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash., DC | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County | | MD. |
| 10. CITY OR TOWN OF DEATH: Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Telephone Operator | 12b. KIND OF BUSINESS OR INDUSTRY: Fed. Gov't. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD | 13b. COUNTY: Mont. | 13c. CITY OR TOWN: Kensington | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS / ZIP CODE: 3411 University Blvd. W 20895 | |
| 14. FATHER'S NAME First: William Middle: Henry Last: Herbert | | | 15. MOTHER'S MAIDEN NAME First: Mary Middle: Catherine Last: Greenfield | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 578-18-1072 | 17. INFORMANT ADDRESS: MARY JEANNE GORTON Jean Gorton 3515 Flyers Mill Ct. Kensington MD 20895 | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary Arrest — Approximate interval between onset and death: Minutes

DUE TO, OR AS A CONSEQUENCE OF (b): Senile Causation Arteriosclerosis — Years

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/11/88 to 19 84, to 12/12/88, that (I/we) last saw the deceased alive on 12/11/88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.

22b. SIGNATURE: Alan S. Kermaier, MD — DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/12/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ALAN S. KERMAIER, MD — 22e. ADDRESS: 1033 GEORGIA AVE. S. MD 20902

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/16/88 | 23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem. | 23d. LOCATION CITY OR TOWN: Suitland, MD | COUNTY / STATE |

24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons, Inc. — ADDRESS: 5130 WI Ave. NW Wash., DC 20016

25. DATE REC'D BY REGISTRAR: DEC 14 88

26. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 72 hours after death. Unless removal is required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be detached at once with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 20

DHMH - 16 60M 7/84
(VRA 15, 4)

17175 DEC 27 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

88 36990 REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Cinderella Middle: Mary Last: Carpenaro | | | 2a. DATE OF DEATH Month/Day/Year: 12/12/88 | 2b. HOUR: 0919 A.M. | |
| 3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH Month/Day/Year: 5-20-08 | 6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD | | |
| 10. CITY OR TOWN OF DEATH: Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerk | 12b. KIND OF BUSINESS OR INDUSTRY: Dept. Store | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: P.G. | 13c. CITY OR TOWN: Hyattsville | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 3415 Purdue Street 20783 | |
| 14. FATHER'S NAME First: Michael Middle: Last: Manilli | | | 15. MOTHER'S MAIDEN NAME First: Pauline Middle: Last: Leli | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO: 579-24-4339A | 17. INFORMANT (Daughter) ADDRESS: Pauline Baxter | 3415 Purdue Street Hyattsville, Md. 20783 | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cardiorespiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Squamous cell carcinoma of lung with metastasis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 11/3, 19 88, to 12/12, 19 88, that (I) (we) last saw the deceased alive on 12/11, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: Pimolvarn Limpuangthip | DEGREE: M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12/12/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): PIMOLVARN LIMPUANGTHIP | 22e. ADDRESS: 6201 Riverdale Rd #102 Riverdale, MD 20737 | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/14/88 | 23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Washington, D.C. | |
| 24. FUNERAL DIRECTOR AND ADDRESS: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781 | | 25a. DATE REC'D BY REGISTRAR: DEC 19 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

019357 JAN 17 89

d - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36991 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | Frances / F. / Caron | 2a. DATE OF DEATH MONTH DAY YEAR | December 23, 1988 | 2b. HOUR | 1:17 AM |
| 3. SEX | Female | 4. RACE | White | 5. DATE OF BIRTH MONTH DAY YEAR | 8/ 6/ 15 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 73 YRS | IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Wash.D.C. | 7b. CITIZEN OF WHAT COUNTRY? | USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH | Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Montgomery General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | University of Md. |
| 12b. KIND OF BUSINESS OR INDUSTRY | Secretary | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Md. | 13b. COUNTY | Mont. | 13c. CITY OR TOWN | S.S. |
| 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | | 13e. STREET ADDRESS | 3393 S.Leisure World Blvd. | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | Floyd / H. / Fearson | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Mabel / G. / Death | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | N/A | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | 213 48 5637 |
| 17. INFORMANT ADDRESS | Victor L.Caron (Husband) Same as 13E | | | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pulmonary edema — Approximate interval between onset and death: Days

DUE TO, OR AS A CONSEQUENCE OF

(b) Acute myocardial infarction — Days

DUE TO, OR AS A CONSEQUENCE OF

(c) Atherosclerotic coronary artery disease — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

Renal failure

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | NA | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES ☐ NO ☒ | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ | |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | NA | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | | | |

22a. I certify that (I) this hospital attended the deceased from Dec. 18, 19 88, to Dec. 23, 19 88, that (I) (we) last saw the deceased alive on Dec 22, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Joan R Kumer MD | DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ | 22c. DATE SIGNED: 12/23/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | Joan R. Kumar, M.D. / for Oliver Lawless | 22e. ADDRESS | M.D. 3701 Rossmoor Blvd. S.S.Md. |

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Burial | 23b. DATE | 12/27/88 | 23c. NAME OF CEMETERY OR CREMATORY | Ft.Lincoln |
| 23d. LOCATION CITY OR TOWN | Brentwood | COUNTY | PG | STATE | Md. |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | Hines/Rinaldi 11800 New Hamp.Ave.S.S.Md | 25a. DATE REC'D BY REGISTRAR | DEC 27 '88 | 25b. REGISTRAR'S SIGNATURE | Julia Davidson-Randall |

117569 DEC 30 88

1 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

88 REG. NO 36992

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| MARY | C. | CASEY | 12-10-88 | 1155 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 06 20 1916 | 72 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| WASHINGTON, DC | USA | MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | MONTGOMERY MD |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| TAKOMA PARK | WASHINGTON ADVENTIST HOSPITAL | HOMEMAKER | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MARYLAND | PR GEORGES | ADELPHI | YES ☐ NO ☐ | 1836 METZEROTT RD #703 20783 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| JOSEPH | | LEE | CATHERINE | CECELIA | COLLINS |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 579-10-0556 | DAUGHTER ELIZABETH L. CARR | 3334 BUCHANAN ST #202 MT. RAINIER, MD 20712 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Squamous cell lung cancer with cerebral metastasis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 9 mos

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from March 19 88 to December 19 88, that (I) (we) last saw the deceased alive on 12-10 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Kai-Yin Yeung | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12-10-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Kai-Yin Yeung, M.D. | 8926 Woodyard Rd #201 Clinton MD 20735 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | DEC 14, 1988 | FT. LINCOLN CEMETERY | BRENTWOOD PRINCE GEORGES MD |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| FRANCIS J. COLLINS, JR. | 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901 | DEC 12 '88 | Julia Davidson Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, other than a natural event, the medical examiner must be notified at once.

Kondar 10 BP

DHMH - 16 60M 7/84
(VRA 15, 4)

VOIDED DEATH CERTIFICATE NUMBER 88-36993

Baby Girl Cavanaugh, 11/25/88 - Mont. Co.

SEE FETAL DEATHS

019470 JAN 12 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36994
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 ... injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate ... signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial Transit Permit ... Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene ... burial, cremation, or removal.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: FRANK MIDDLE: FRANK LAST: CEASAR | | | | 2a. DATE OF DEATH: December 21, 1988 (MONTH DAY YEAR) | 2b. HOUR: 6A M |
| 3. SEX: MALE | 4. RACE: BLACK | 5. DATE OF BIRTH: JULY 1, 1922 (MONTH DAY YEAR) | | 6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): South Carolina | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH: WHEATON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MANOR CARE WHEATON | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired/Industrial Engineer/ | 12b. KIND OF BUSINESS OR INDUSTRY: DC Govt. |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: District of | 13b. COUNTY: Columbia | 13c. CITY OR TOWN: Washington | 13d. INSIDE CITY LIMITS? YES XX NO ☐ | 13e. STREET ADDRESS / ZIP CODE: 3712 - 13th Street, N.W.; (20010) | |
| 14. FATHER'S NAME FIRST: Judge MIDDLE LAST: Ceasar | | | 15. MOTHER'S MAIDEN NAME FIRST: Lugenia MIDDLE LAST: Graves | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 251-14-1819 | 17. INFORMANT ADDRESS: 3712 - 13th Street,N.W.; (20010) | Christine Davis Ceasar(wife)Washington,D.C. | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): STOMACH CANCER - METASTATIC

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 10-29-85, 19____, to present, 19____, that (I) (we) last saw the deceased alive on 12-15, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Joel Kalman | DEGREE: M.D. | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12-21-88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOEL KALMAN | | 22e. ADDRESS: 6111 EXECUTIVE BLVD, ROCKVILLE, MD 20852 | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Dec.27,1988 | 23c. NAME OF CEMETERY OR CREMATORY: Maryland National Memorial Park | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Laurel,P.G.Co.,Maryland | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: LATNEY'S FUNERAL SERVICE, INC. 3831 Georgia Aveune,N.W.;Washington,D.C. 20011 | | 25a. DATE REC'D. BY REGISTRAR: JAN 12 1989 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

BP 999994

DHMH - 16 50M 4/83
(VRA 15, 4)

0 1 5 9 7 1 DEC 13 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 036995

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: RUBY JOANN CHAPMAN | | | | 2a. DATE OF DEATH MONTH DAY YEAR: DECEMBER 6 1988 | 2b. HOUR: 8:30 A M |
| 3. SEX: FEMALE | 4. RACE: CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR: NOVEMBER 24 1942 | 6. AGE (IN YEARS LAST BIRTHDAY): 46 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): IDAHO | 7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH: BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY: U.S.M.C. | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| VIRGINIA | FAIRFAX | W.SPRINGFIELD | YES [ ] NO [ ] | 6116 HARMON PLACE 22153 |

| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |
|---|---|
| H. GRANT SANBORN | DOROTHY JONES |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| YES | 1965-1987 | 518-50-9867 | BILLY B.CHAPMAN,6116 HARMON PLACE, |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — W.SPRINGFIELD, VA 22153

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): METASTATIC CARCINOMA OF THE BREAST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [X] NO [ ] | YES [X] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 1, 1988 to DECEMBER 6, 1988, that (I) (we) last saw the deceased alive on DECEMBER 6, 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE DEGREE | ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN | 22c. DATE SIGNED |
|---|---|---|
| R. P. Dolan MD | [ ] [ ] [X] | 07 Dec 88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| R. P. DOLAN, LT, MC, USNR | NAVAL HOSPITAL BETHESDA, MD 20814-5011 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Burial | Dec.9,1988 | Arlington National | Arlington,Virginia |

| 24. FUNERAL DIRECTOR NAME ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Ives-Pearson Funeral Homes,Arlington,va. | DEC 12 1988 | Julia Brandon-Landers |

DHMH - 16 50M 1/81 (VRA 15, 4)

0 1 7 4 1 4 DEC 28 88

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 36996 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the completed certificate to the registrar who issued the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other [illegible] the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: MOLLIE | MIDDLE | LAST: CHARNES | 2a. DATE OF DEATH MONTH DAY YEAR: DECEMBER 22, 1988 | 2b. HOUR: 7:30A M | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR: JUNE 1, 1910 | 6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW JERSEY | 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD | | |
| 10. CITY OR TOWN OF DEATH: SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): MERCHANT | 12b. KIND OF BUSINESS OR INDUSTRY: GROCERY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND | 13b. COUNTY: MONTGOMERY | 13c. CITY OR TOWN: SILVER SPRING | 13d. INSIDE CITY LIMITS? YES XX NO ☐ | 13e. STREET ADDRESS: 14508 HOMECREST ROAD 20906 | |
| 14. FATHER'S NAME FIRST: JOSEPH | MIDDLE | LAST: SUSSEL | 15. MOTHER'S MAIDEN NAME FIRST: ESTHER | MIDDLE | LAST: MINNICK |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 578-52-8804A | 17. INFORMANT: LENORE L. GOTTS, | ADDRESS: 805 KENBROOK DRIVE SILVER SPRING, MARYLAND | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Respiratory Failure | 48 hrs. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Chronic Obstructive Pulmonary Disease | many years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CHF, Possible Staphylococcus epidermidis sepsis, Interstitial Fibrosis

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that ~~this~~ (this hospital) attended the deceased from December 15, 19 88, to December 22, 19 88, that ~~I~~ (we) last saw the deceased alive on December 21, 19 88, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Ruth Kevess-Cohen M.D. | DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12-22-88 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): RUTH KEVESS-COHEN M.D. | 22e. ADDRESS: 1106 SPRING STREET / SILVERSPRING MD | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL: BURIAL | 23b. DATE: 12/25/1988 | 23c. NAME OF CEMETERY OR CREMATORY: NATIONAL CAPITOL HEBREW CEMETERY | 23d. LOCATION (CITY OR TOWN): CAPITOL HEIGHTS | PRINCE GEORGES MARYLAND |
| 24. FUNERAL DIRECTOR (NAME): DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME (ADDRESS): 232 CARROLL STREET, N. W., WASHINGTON, D. C. | | 25a. DATE REC'D. BY REGISTRAR: DEC 27 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Kopelow | |

4 BP

DHMH - 16 50M 1/81 (VRA 15, 4)

018354 JAN 16 89

Item#18a,22a per med Film G649 3/31/89 cm

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO. 3 6 9 9 7

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: ELAYSHA MIDDLE: | LAST: CHASE | | | | 2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ MONTH DAY YEAR: 12-22-88 | 2b. HOUR: M |
| 3. SEX: Female | 4. RACE: Black | 5. DATE OF BIRTH MONTH DAY YEAR: Nov. 22, 1988 | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.: | IF UNDER 1 YR. MONTHS: 1 DAYS: | IF UNDER 24 HRS. HOURS: MIN: | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 12-22-88 | 2d. HOUR: 9:00a M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash. D.C. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH: Rockville | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Hospital | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): None | 12b. KIND OF BUSINESS OR INDUSTRY: |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | Montg. | Gaithersburg | YES ☐ NO ☐ | 9424 Merust Lane/ 20879 |

| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |
|---|---|
| Wayne Chase | Patricia Twyman |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | | None | Patricia Twyman (mother) same as #13 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Sudden infant Death syndrome

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|

| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes [X], Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Margarita A Korell M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED: 12-24-88

EXAMINER'S NAME (TYPE OR PRINT): Margarita A. Korell, M.D. ADDRESS: 111 Penn Street

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Burial | 12-29-88 | Gate of Heaven Cem. | Silver Spring, Montg. MD |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| George R. Snowden | Rockville, MD 20850 | JAN 3 1989 | Richie Davidson-Kendall |

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07 84 BP256

DHMH - 17
(VR A15 ME (5))

016227 DEC 15 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 036998

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Rudolph | Middle: Frank | Last: Chelikowsky | 2a. DATE OF DEATH Month: 11 Day: 21 Year: 88 | 2b. HOUR: 11:16 PM | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH Month: 6 Day: 16 Year: 15 | 6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery Co. MD. | | |
| 10. CITY OR TOWN OF DEATH: Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Shipping Supervisor-DuPont | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Ohio | 13b. COUNTY: Pickaway | 13c. CITY OR TOWN: Circleville | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 160 Montclair Ave. | |
| 14. FATHER'S NAME First: Frank | Middle: | Last: Chelikowsky | 15. MOTHER'S MAIDEN NAME First: Katherine | Middle: | Last: Biebel |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): NOT | 16b. SOCIAL SECURITY NO.: 079-03-2256 | 17. INFORMANT: Frances Chelikowsky | ADDRESS: same as #13 | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Electrocution Accidental — Approximate interval between onset and death: 30 min.

DUE TO, OR AS A CONSEQUENCE OF (b): Severe coronary disease — Approximate interval between onset and death: Years

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerosis — Approximate interval between onset and death: Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 11/21 19 88 to 11/21 19 88 that (I) (we) saw the deceased alive on 11/21 19 88 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 11/21/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): [signature] — 22e. ADDRESS:

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 11-26-88 | 23c. NAME OF CEMETERY OR CREMATORY: St. Joseph's Cemetery | 23d. LOCATION CITY OR TOWN: Circleville STATE: Ohio |

24. FUNERAL DIRECTOR NAME AND ADDRESS: Ives-Pearson Funeral Homes, Arlington, Va. 22201

25a. DATE REC'D BY REGISTRAR: DEC 9 1988 — 25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

19010 JAN 13 89

1 - FOR STATE REGISTRAR

REG. NO. 88 36999

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| ETHEL | JULIET | CHENIAE | 12-24-88 | 7 55 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN. |
|---|---|---|---|---|---|
| Female | Caucasian | 7 2 16 | 72 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Kentucky | USA | MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | Montgomery MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Silver Spring | Holy Cross Hospital | Dept. Manager | Hecht Co. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | P.G. | Laurel | YES ☒ NO ☐ | 7802-21 Spinnaker Rd. 20707 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Eugene | | Dunn | Hazel | | Holloway |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (ADDRESS) |
|---|---|---|---|
| NO | | 403-09-1148 | 2311 Pimmit Drive, #1218 East, Falls Church, Va. 22043 Gilbert W. Cheniae, Jr., |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | ADENOCARCINOMA OF LEFT LUNG | 4 MOS |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
CHRONIC OBSTRUCTIVE PULMONARY DISEASE

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1R, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from AUGUST, 19 88, to DECEMBER 24, 19 88, that ~~he~~ (we) last saw the deceased alive on DECEMBER 23, 19 88, and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (we) (~~did~~) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| James G. Brown MD | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/24/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| JAMES A. BROWN MD | 14808 PHYSICIANS LANE ROCKVILLE, MD. 20850 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12-28-88 | George Washington Cem. | Adelphi, PG, Maryland |

| 24. FUNERAL DIRECTOR (NAME) (ADDRESS) | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland | JAN 3 '89 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/removal permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/removal permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

017062 DEC 22 88

REG. NO. 88 37000

1. DECEASED NAME (First, Middle, Last): RAIMOND ANTHONY CLARK
2a. DATE OF DEATH (Month, Day, Year): DECEMBER 14 1988
2b. HOUR: 11:34 A.M.
3. SEX: MALE
4. RACE: BLACK
5. DATE OF BIRTH (Month, Day, Year): DECEMBER 10 1988
6. AGE (In years last birthday): YRS. — If under 1 year: Months — Days: 4 — If under 24 hrs.: Hours — Min.
7a. BIRTHPLACE (State or Foreign Country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD
10. CITY OR TOWN OF DEATH: BETHESDA
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address): NAVAL HOSPITAL
12a. USUAL OCCUPATION (Type of work for most of working life): N/A
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (If nursing home or other institution, give residence before admission)
13a. STATE: MARYLAND
13b. COUNTY: PRINCE GEO'S
13c. CITY OR TOWN: SUITLAND
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS: 3802 REGENCY PARKWAY 20746

14. FATHER'S NAME (First, Middle, Last): KENNETH LEE CLARK
15. MOTHER'S MAIDEN NAME (First, Middle, Last): WHITNEY LYNN COLEMAN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown): NO
(If yes, give war or dates): -
16b. SOCIAL SECURITY NO.: N/A
17. INFORMANT ADDRESS: WHITNEY COLEMAN-CLARK, 3802 REGENCY PARKWAY, APT. 302, SUITLAND, MD 20746

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — Approximate interval between onset and death
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PREMATURITY
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☒ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify Medical Examiner)
21b. TIME OF INJURY (Hour A.M. P.M., Month, Day, Year 19)
21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part 1 or Part 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (At home, street, factory, office, farm, etc.)
21f. LOCATION: Street — City or Town — County — State

22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 10, 19 88, to DECEMBER 14, 19 88, that (I) (we) last saw the deceased alive on DECEMBER 14, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/20/88
22d. PHYSICIAN'S NAME (Type or Print): J. NADING, CDR, MC, USN
22e. ADDRESS: NAVAL HOSPITAL, BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (Specify): RELEASED TO NAVAL HOSPITAL, BETHESDA, MD
23b. DATE: 12/22/88
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION: City or Town — County — State
24. FUNERAL DIRECTOR: Name — Address
25a. DATE ACCEPTED BY REGISTRAR: DEC 22 1988
25b. REGISTRAR'S SIGNATURE: Giulia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 37001

0184 4 JAN -9 89

1. DECEASED NAME (TYPE OR PRINT): FIRST JOSEPH MIDDLE E LAST CLARK SR
2a. DATE OF DEATH: MONTH 12 DAY 17 YEAR 88
2b. HOUR: 5:35 A M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: MONTH 10 DAY 4 YEAR 03
6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON, DC
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: SILVER SPRING
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): PLUMBER
12b. KIND OF BUSINESS OR INDUSTRY: SELF-EMPLOYED

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY: MONTGOMERY
13c. CITY OR TOWN: WHEATON
13d. INSIDE CITY LIMITS? YES [ ] NO [ ]
13e. STREET ADDRESS: 2627 WEISMAN ROAD 20902

14. FATHER'S NAME: FIRST THOMAS MIDDLE C. LAST CLARK
15. MOTHER'S MAIDEN NAME: FIRST MARGARET MIDDLE MARY LAST WHEELER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 578-03-0953
17. INFORMANT ADDRESS: MARY M. CLARK/WIFE/SAME AS 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIOGENIC SHOCK
DUE TO, OR AS A CONSEQUENCE OF (b): ACUTE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF (c): CORONARY DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 72 hrs -

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): DIABETES MELLITUS - EMPHYSEMA

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from MARCH 17 19 87, to Dec 17 88 19 88, that (I) (we) last saw the deceased alive on Dec 16 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: R. A. Matheus MD
DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 12-17-88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): RAFAEL A. MATHEUS, MD
22e. ADDRESS: 13018 GEORGIA AVE. WHEATON, MD 20906

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: DEC 20, 1988
23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEM.
23d. LOCATION: CITY OR TOWN SILVER SPRING COUNTY MONTGOMERY STATE MD

24. FUNERAL DIRECTOR NAME AND ADDRESS: FRANCIS J. COLLINS, JR.
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901
25. DATE RECEIVED BY REGISTRAR: DEC 19 88
REGISTRAR'S SIGNATURE: Patricia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 15

DHMH - 16 50M 1/87 (VRA 15, 4)

019745 JAN 1989

1b FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37002 REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Donald | GRAY | Coe | 12 - 27 - 88 | 9:30 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR: MONTHS DAYS | IF UNDER 24 HRS: HOURS MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 7 3 28 | 60 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| WASH. D.C. | U.S.A. | | MONTGOMERY Co. MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| ROCKVILLE | Shady Grove Nursing Center | APPRAISER | ESTATE WMATA REAL- |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Md. | MONTGOMERY | ROCKVILLE | YES ☒ NO ☐ | 750 AZALEA DR. 20850 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| LOWRY | N. | COE | EDITH | HAYWOOD | GRAY |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| NO | ------ | 578-34-1991 | LOWRY N. COE JR. 15641 HADDONFIELD WAY, DARNESTOWN, Md |

**MEDICAL CERTIFICATION**

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Progressive Polyneuropathy

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| N/A | | YES ☐ NO ☒ | YES ☐ NO ☒ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | N/A 19 | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) this hospital attended the deceased from 11.2.88 19 88 to 12.27 19 88 that (I) (we) last saw the deceased alive on 12.27 19 88 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Steven P. Devas MD | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | 12/27/1988 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| STEVEN P. DEVAS, M.D | 9701 Medical Ctr Dr Rockville |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| CREMATION | 12-28-1988 | CHAMBERS CREMATORY | RIVERDALE, | P.G.C. | Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| W. W. CHAMBERS CO. INC. | SILVER SPRING, Md. 20910 | DEC 29 '88 | Julia Davidson-Randall |

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 10

DHMH - 16 60M 7/84 (VRA 15, 4)

18273 JAN -6 89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

S 8 37003
REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: PINCUS; MIDDLE: ; LAST: COHEN (COHEN) | | | 2a. DATE OF DEATH MONTH: 12; DAY: 24; YEAR: 88 | | 2b. HOUR: 706 P M |
| 3. SEX: MALE | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH: 7; DAY: 15; YEAR: 96 | 6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS | IF UNDER 1 YEAR MONTHS: ; DAYS: | IF UNDER 24 HRS HOURS: ; MIN.: |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Poland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH: ROCKVILLE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HEBREW HOME OF GR. WASHINGTON | | 12a. USUAL OCCUPATION (TYPE OF WORK [FOR MOST OF WORKING LIFE]): Business Owner | 12b. KIND OF BUSINESS OR INDUSTRY: (Ret.) Grocery | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD | 13b. COUNTY: MONTGOMERY | 13c. CITY OR TOWN: Rockville | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 6121 Montrose Road (20852) | |
| 14. FATHER'S NAME FIRST: Samuel; MIDDLE: ; LAST: Cohen | | | 15. MOTHER'S MAIDEN NAME FIRST: Chana; MIDDLE: ; LAST: Halperin | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES): -------- | 16b. SOCIAL SECURITY NO.: 084-03-3646 | 17. INFORMANT ADDRESS: Myron Cohen; 1051 Saxony Drive; Highland Park, Illinois 60035 | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiorespiratory arrest | Seconds |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Alzheimers Disease | years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Chronic degenerative neurologic process | year |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 5-7 19 87 to 12-24 19 88, that (I) (we) last saw the deceased alive on (12-24-88) 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| [signature] | MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12-25-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Daniel A. Jaller, MD | 6121 Montrose Road; Rockville, Md. 20852 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12/27/88 | Sharon Gardens Cemetery; | Valhalla, New York |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| DANZANSKY-GOLDBERG MEMORIAL CHAPELS | 1170 Rockville Pike; Rockville, Md. 20852 | JAN 04 1989 | [signature] |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3.

BP

DHMH-16 50M 1/81 (VRA 15, 4)

017499 DEC 28 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37004
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: SUSAN; MIDDLE: B; LAST: COHN | | | 2a. DATE OF DEATH MONTH DAY YEAR: December 16, 1988 — 2b. HOUR: 10:15PM |
| 3. SEX: FEMALE | 4. RACE: CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR: SEPT 30 1943 | 6. AGE (IN YEARS LAST BIRTHDAY): 45 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON, DC | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED XX ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD |
| 10. CITY OR TOWN OF DEATH: Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 13804 Blair Stone Lane | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Home |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Silver Spring | YES ☒ NO ☐ | 13804 Blair Stone Lane (20906) |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| MEYER BARWESS | ALMA KLINE |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| NO | — — — — | 578-56-8549 | SILVER SPRING, MD 20906 ROBERT M COHN; HUSBAND; 13804 BLAIRSTONE |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiovascular arrest | |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | ovarian cancer | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO XXX | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that X (this hospital) attended the deceased from 7/20, 19 88, to December 16, 19 88, that X (we) last saw the deceased alive on 11/29, 19 88, and that in X (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| SHH | MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/17/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| SHERILYNN HUMMEL, M.D. | 10215 Fernwood Road, #308; Bethesda, Md. 20814 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12/20/88 | Judean Memorial Gardens, | Olney; Montgomery; Md. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852 | DEC 22 1988 | Julia Davidson Randall |

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG NO. 37005

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

0163 DEC 15 88

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST: Roger | MIDDLE: Temple | LAST: Cole | 2a. DATE KNOWN OF DEATH / ESTIMATED: XX / ☐ MONTH 12 DAY 12 YEAR 1988 | 2b. HOUR: M | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: MONTH 08 DAY 20 YEAR 67 | 6. AGE (IN YEARS) LAST BIRTHDAY: 21 YRS. | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. | 2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 12 YEAR 1988 | 2d. HOUR: 12:30 a.m. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Morocco | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD. | | | | |
| 10. CITY OR TOWN OF DEATH: Poolesville | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 18755 Darnstown Rd. - Rt. 28 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Student | 12b. KIND OF BUSINESS OR INDUSTRY: College | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE: Virginia | 13b. COUNTY: Fairfax | 13c. CITY OR TOWN: Reston | 13d. INSIDE CITY LIMITS? YES ☐ NO XX | 13e. STREET ADDRESS: 2714 Soapstone Drive | 22091 | | |
| 14. FATHER'S NAME: FIRST Temple MIDDLE Gatewood LAST Cole | | | 15. MOTHER'S MAIDEN NAME: FIRST Betty MIDDLE Booth LAST Coleman | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): N/A | 16b. SOCIAL SECURITY NO.: 223-08-2679 | 17. INFORMANT: Betty C. Cole | ADDRESS: Same as #13 | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8150
IMMEDIATE CAUSE (a) Thermal Injury and Compression Injury
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES XX NO ☐ |
| 21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:20AM 12-12 1988 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) driver in auto/fixed object impact with subsequent fire |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road | 21f. LOCATION STREET 18755 Darnstown Rd. - Rt. 28, CITY OR TOWN Mont. Co., COUNTY Md. STATE |

22a. I certify that I took charge of the remains described above, held an Autopsy XX Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Chief MEDICAL EXAMINER DATE SIGNED 12-12-88

EXAMINER'S NAME (TYPE OR PRINT) John E. Smialek, M.D. ADDRESS 111 Penn St., Balto., Md. 21201

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation | 23b. DATE: 12-12-88 | 23c. NAME OF CEMETERY OR CREMATORY: Security Process | 23d. LOCATION CITY OR TOWN Catonsville COUNTY Ba STATE MD |
| 24. FUNERAL DIRECTOR NAME AND ADDRESS: Cremation Society of MD, 299 Frederick Rd. Balto., MD 21228 | | 25a. DATE REC'D BY REGISTRAR: DEC 13 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landeros |

07/84 BP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

88 37006 REG. NO.

017028 DEC 22 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Thomas Middle: Edward Last: Collins | 2a. DATE OF DEATH Month: 12 Day: 16 Year: 88 | 2b. HOUR 0600 M | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH Month: 7 Day: 25 Year: 1928 | 6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS; IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. |
| 10. CITY OR TOWN OF DEATH: Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired | 12b. KIND OF BUSINESS OR INDUSTRY: Montg. County Schools |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Silver Spring | YES [X] NO [ ] | 13609 Middevalle Lane 20906 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last |
|---|---|
| William Guy Collins | Grace M. Schoolfield |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| Yes | 1950 - 1956 | 238-34-4466 | Dorothy M. Collins- wife- (same as 13e) |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | RESPIRATORY FAILURE | 4 hrs |
| DUE TO, OR AS A CONSEQUENCE OF (b) | METASTATIC MALIGNANCY | 2 months |
| DUE TO, OR AS A CONSEQUENCE OF (c) | LUNG CANCER - LARGE CELL | 14 months |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from May 14, 19 88, to Dec 16, 19 88, that (I) (we) last saw the deceased alive on Dec 16 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | 22c. DATE SIGNED |
|---|---|---|---|---|
| Eugene P. Libre | MD | ATTENDING PHYSICIAN [ ] | MEDICAL DIRECTOR [X] | STAFF PHYSICIAN [ ] | 16 Dec 88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| EUGENE P. LIBRE MD | 10400 Connecticut Ave KENSINGTON, MD. 20895 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | 12-19-1988 | Metropolitan Crematory | Alexandria / Virginia |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Hines/Rinaldi Funeral Home | 11800 N.H. Ave. Sil. Spr. Md. | DEC 20 1988 | Julia Davidson-Randall |

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 037007

0184 72 JAN - 3 89

1. DECEASED NAME (TYPE OR PRINT): First: Virginia; Middle: S.; Last: Colton

2a. DATE OF DEATH: Month: Dec.; Day: 18; Year: 1988

2b. HOUR: 5:46 PM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: Month: Sept.; Day: 17; Year: 1899

6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS.

IF UNDER 1 YEAR — MONTHS: ; DAYS: ; IF UNDER 24 HRS. — HOURS: ; MIN.:

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ohio

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Carriage Hill-Bethesda

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: At Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Bethesda

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 5215 Cedar Lane 20814

14. FATHER'S NAME: First: John; Middle: H.; Last: Smith

15. MOTHER'S MAIDEN NAME: First: Effie; Middle: Belle; Last: Thompson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): ---

16b. SOCIAL SECURITY NO.: 577-03-3264

17. INFORMANT ADDRESS: Ann S. Flatter 124 Turnbull Rd. Cedarville Ohio

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Generalized arteriosclerosis

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2):

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from Nov 29, 19 88, to Dec 18, 19 88, that (I) (we) last saw the deceased alive on 12/16, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John B. Umhau DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12/16/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): John B. Umhau MD

22e. ADDRESS: 8805 Conn. Ave. Chevy Chase MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 12-21-88

23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery

23d. LOCATION: CITY OR TOWN: Washington, D.C.; COUNTY; STATE

24. FUNERAL DIRECTOR: NAME: Joseph Gawler's Sons, Inc. ADDRESS: Washington, D.C.

25a. DATE REC'D. BY REGISTRAR: DEC 21 '88

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

R

BP 6

DHMH - 16 60M 7/84
(VRA 15, 4)

019026 JAN 18 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

B 8 3 7 0 0 8
REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| IDA | F | COLVIN | 12 22 88 | 5:50 M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN. |
|---|---|---|---|---|---|
| Female | White | 5 21 96 | 92 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| VA | USA | | MONTGOMERY MD |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Silver Spring | Holy Cross Hospital | CLERK | WOODIES |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | PR GEORGES | Adelphi | YES ☐ NO ☐ | 2101 AMHERST ROAD 20783 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| ODIS | C. | SPITZER | SUSIE | E. | WATTS |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| NO | | 577-07-0261 | ETHEL M. SPARROUGH/DAUGHTER/SAME AS 13 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Acute cardiorespiratory arrest | minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Arteriosclerotic cardiovascular Dis | 10 yrs. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 12/22 19 88, to 12/22 19 88, that (I) (we) last saw the deceased alive on 12/22 19 88, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|---|
| Myron L Lenkin | MD | | 12/22/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| MYRON L. LENKIN | 2304 STORE HILL RD WHEATON MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| BURIAL | DEC 27, 1988 | FORT LINCOLN CEMETERY | BRENTWOOD PRINCE GEORGES MD |

| 24. FUNERAL DIRECTOR NAME ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901 | DEC 27 88 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and this certificate shall not be signed by the attending physician or filed with the State Department of Health and Mental Hygiene prior to the completion of the medical examiner's investigation.

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

015927 DEC 13 88

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO 88 37009

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| BETTY | S. | CONNER | DECEMBER 8, 1988 | 6 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | MAY 3, 1931 | 57 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Georgia | USA | | MONTGOMERY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT HOSPITAL, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| SILVER SPRING | 2100 EDNOR ROAD | HOMEMAKER | HOME |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD. | MONT. | SILVER SPRING | YES ☐ NO ☒ | 2100 EDNOR ROAD 20904 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| JOHN | S. | SCHELL | LENA | | ALLISTON |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 253-44-4284 | CHARLES E. CONNER, JR. | SAME AS #13 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Small Cell Lung cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 mos
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
Lung, liver, bone marrow metastasis.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 10/17, 19 88, to 12/8, 19 88, that (I) ~~(we)~~ last saw the deceased alive on 11/28, 19 88, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
|---|---|---|---|
| Donald E. Dillon | MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 8 Dec 88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Donald E. Dillon | 2901 Sandy Spring Rd Laurel, MD 20707 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | December 9, 1988 | Balt./Wash. | Laurel, P.G., Maryland |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Muriel H. Barber Laytonsville, Md. 20879 | DEC 12 1988 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on page 1, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 37010

018472 JAN 88

1a. DECEASED NAME (TYPE OR PRINT) — FIRST: Crescentia; MIDDLE: M.; LAST: Connor

2a. DATE OF DEATH — MONTH DAY YEAR: December 18, 1988

2b. HOUR: 5:50pm M

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH — MONTH DAY YEAR: March 10, 1903

6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Rockville Nursing Home

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): School Teacher

12b. KIND OF BUSINESS OR INDUSTRY: Education

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Rockville

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS / ZIP CODE: 809 Aster Blvd./20850

14. FATHER'S NAME — FIRST: Michael; MIDDLE: ; LAST: McGrath

15. MOTHER'S MAIDEN NAME — FIRST: Ellen; MIDDLE: ; LAST: Fallon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): -

16b. SOCIAL SECURITY NO.: 207 01 0443

17. INFORMANT: (Daughter) Patricia Coogan — ADDRESS: Same as line #13.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Alzheimers Disease

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: over 10 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (~~XXXXXX~~) attended the deceased from 2-21, 19 84, to 12-18-, 19 88, that (I) (~~XX~~) last saw the deceased alive on 11-21, 19 88, and that in (my) (~~XX~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~XXXXX~~) (did not) view the body after death.

22b. SIGNATURE: Frauke Wyphal — DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: December 18, 1988

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Frauke Westphal, M.D.

22e. ADDRESS: 809 Veirs Mill Rd. Rockville, Md. 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: December 21, 1988

23c. NAME OF CEMETERY OR CREMATORY: Our Mother of Sorrows Cemetery

23d. LOCATION — CITY OR TOWN; COUNTY; STATE: Finch Hill Lacawanna Penn.

24. FUNERAL DIRECTOR — NAME: Robert A. Pumphrey Funeral Homes/ Rockville, Inc. — ADDRESS: 300 West Montgomery Avenue, Rockville, Maryland

25a. DATE REC'D. BY REGISTRAR: DEC 20 '88

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 (c) any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83
(VRA 15, 4)

015290 DEC -6 88 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37611 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner, must be notified at once.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Marie | MIDDLE: M. | LAST: Connors | |
| 2a. DATE OF DEATH MONTH DAY YEAR: December 1, 1988 | 2b. HOUR: 7:33PM | | |
| 3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: June 10, 1914 | 6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS; IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New Jersey | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD. |
| 10. CITY OR TOWN OF DEATH: Germantown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 20311 Cabana Drive | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Bookkeeper | 12b. KIND OF BUSINESS OR INDUSTRY: Department Store |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Germantown | YES ☐ NO ☒ | 20311 Cabana Drive/20874 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Harry | | Eve | Caroline | | Badger |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Daughter) | ADDRESS |
|---|---|---|---|---|
| No | - | 151 09 1077 | Mary Connors | Same as line #13 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Brain metastases | 3 mos |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Lung Cancer | 3 mos |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 11-1, 19 88, to 12-1, 19 88, that (I) (we) last saw the deceased alive on 11-22, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
|---|---|---|---|
| Stanley B Benjamin | MD | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐ | Dec. 1, 1988 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Stanley B. Benjamin, M.D. | 3800 Reservoir Rd., Washington, D.C. 20007 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial/Transit | December 02, 1988 | Holy Cross Cemetery | N. Arlington/Hudson/New Jersey |

| 24. FUNERAL DIRECTOR NAME | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Md. | DEC 2 1988 | Julia Davidson Randall |

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

017731 DEC 30 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37012
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | Ramona E. Cook | | | 2a. DATE OF DEATH MONTH DAY YEAR | 12-5-88 |
| | | | | 2b. HOUR | 943 PM |
| 3. SEX | FEMALE | 4. RACE | BLACK | 5. DATE OF BIRTH MONTH DAY YEAR | 4 6 55 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 33 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS. HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | NY | 7b. CITIZEN OF WHAT COUNTRY? | USA | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Mont. Co. MD. | | | | |
| 10. CITY OR TOWN OF DEATH | Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Holy Cross Hosp. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Manager |
| 12b. KIND OF BUSINESS OR INDUSTRY | Dept comm. | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | ~~Md.~~ DC | 13b. COUNTY | | 13c. CITY OR TOWN | Wash. |
| 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | | 13e. STREET ADDRESS | 128-MADISON ST NW | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | Bobby Owen | | | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Gwen Womble |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | No | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | 241-02-2781 |
| 17. INFORMANT ADDRESS | Lucille J. Womble, Rt.2 Box 5, Randlenan, N.C. | | | | |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) SEPTECEMIA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) NEUTROPENIA 2nd to CHEMOTHERAPY — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10days

DUE TO, OR AS A CONSEQUENCE OF (c) DIFFUSE HISTOLYTIC LYMPHOMA — 3yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): ANEMIA + THROMBOCYTOPENIA

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☒ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from July 1985 to Dec 1988, that (I) (we) last saw the deceased alive on DEC 5th 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED 12/6/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Everhart Hughes | | 22e. ADDRESS 8300 Corporate Dr. Landover, M.D. | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 12-9-1988 | 23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE Washington, D.C. |
| 24. FUNERAL DIRECTOR NAME / ADDRESS McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W. Washington. D.C. | | 25a. DATE REC'D. BY REGISTRAR DEC 13 '88 | 25b. REGISTRAR'S SIGNATURE Lydia Davidson-Randall |

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

017732 DEC 30 88 — FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37013 — REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 12

DHMH - 1650M 1/81 (VRA 15, 4)

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST | DOROTHY | E. | COOLEY | |
| 2a. DATE OF DEATH — MONTH / DAY / YEAR | 12-10-88 | | | 2b. HOUR 10-17 PM |
| 3. SEX | FEMALE | | | |
| 4. RACE | WHITE | | | |
| 5. DATE OF BIRTH — MONTH / DAY / YEAR | 11 | 29 | 19 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 69 YRS. | | | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | MARYLAND | | | |
| 7b. CITIZEN OF WHAT COUNTRY? | USA | | | |
| 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | | | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | MONTGOMERY Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH | BETHESDA | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | SUBURBAN HOSPITAL | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | HOMEMAKER | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | MD | | | |
| 13b. COUNTY | Mont. | | | |
| 13c. CITY OR TOWN | Wheaton | | | |
| 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | | | | |
| 13e. STREET ADDRESS | 2902 Dawson Ave 20902 | | | |
| 14. FATHER'S NAME — FIRST / MIDDLE / LAST | JOHN | W. | GITTINGS | |
| 15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST | MABEL | | WHITTLE | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | NO | | | |
| 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | 219-01-9311 | | | |
| 17. INFORMANT | SON | | | ADDRESS 13527 TURKEY BR PKY ROCKVILLE, MD 20853 |
| | ROLAND O. COOLEY, JR | | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) cardiogenic shock — 2 days

DUE TO, OR AS A CONSEQUENCE OF

(b) Acute Myocardial Infarction — 5 days

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Adult Onset Diabetes Mellatus, Hypertension

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| N/A | N/A | YES ☐ NO ☒ | YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY — HOUR A.M. P.M. / MONTH / DAY / YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| N/A | | N/A | |
| 21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 4/1 19 88, to 12/10 19 88, that (I) (we) last saw the deceased alive on 12/10 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
| Kathryn S. Kirwin | MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/11/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |
| KATHRYN S. KIRWIN MD | | #606 10400 Connecticut Ave Kensington, MD 20895 | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION — CITY OR TOWN / COUNTY / STATE | |
| BURIAL | DEC 13, 1988 | GATE OF HEAVEN CEM. | SILVER SPRING | MONT MD |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901 | 25a. DATE REC'D. BY REGISTRAR | DEC 12 '88 | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall |

0 1 7 7 3 3 DEC 30 88 J - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37014 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Margaret Middle: S. Last: Cooper | | | | 2a. DATE OF DEATH Month: 12 Day: 8 Year: 88 | 2b. HOUR 6:05 AM |
| 3. SEX: female | 4. RACE: White | 5. DATE OF BIRTH Month: Aug. Day: 31, Year: 1913 | 6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS. | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): DC | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH: Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Sales Clerk | 12b. KIND OF BUSINESS OR INDUSTRY: Retail | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: DC | 13b. COUNTY: N/A | 13c. CITY OR TOWN: Wash. DC | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 4535 Reno Rd NW 19999 | |
| 14. FATHER'S NAME First: George Middle: M. Last: Stein | | | 15. MOTHER'S MAIDEN NAME First: Jennie Middle: Elizabeth Last: Graham | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 578 10 3603 | 17. INFORMANT: Elton R. Cooper | ADDRESS: 5507 Hoover St. Beth., MD 20817 | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ACUTE PULMONARY EMBOLUS C INFARTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: HOURS

DUE TO, OR AS A CONSEQUENCE OF (b): CONGESTIVE HEART FAILURE — 1 MONTH

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): NECROTIC ULCERS, DUODENUM, SMALL THYROID

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☒ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (~~this hospital~~) attended the deceased from 12-6 88, 19__, to 12-8 88, 19__, that (I) (~~we~~) last saw the deceased alive on 12-5 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: [signature] | DEGREE: MD | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12/8/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): N. S. SAIA | 22e. ADDRESS: 809 Viers Mill Rd | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation | 23b. DATE: 12/13/88 | 23c. NAME OF CEMETERY OR CREMATORY: Mt. Comfort Crematory | 23d. LOCATION CITY OR TOWN: Alexandria, VA COUNTY / STATE | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: Joseph Gawler's Sons, Inc, 5130 WI Ave. NW Wash., DC | | 25a. DATE REC'D. BY REGISTRAR: DEC 14 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

Received 12/14/88 BP

DHMH - 16 50M 1/81 (VRA 15, 4)

017734 DEC 30 1988

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37015
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as The Burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Almena | MIDDLE: V. | LAST: Costinett | |
| 2a. DATE OF DEATH MONTH: December | DAY: 6 | YEAR: 1988 | 2b. HOUR: 4:29 A M |
| 3. SEX: female | 4. RACE: Cauc | 5. DATE OF BIRTH MONTH: JAN DAY: 6 YEAR: 1909 | 6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON, DC | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Mont. County MD. |
| 10. CITY OR TOWN OF DEATH: Kensington | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Kensington Gards Ng Ctr. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Library | 12b. KIND OF BUSINESS OR INDUSTRY: Administration |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md | 13b. COUNTY: Mont | 13c. CITY OR TOWN: ROCKVILLE | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ |
| 13e. STREET ADDRESS: 16916 Freedom Way 20853 | | | |
| 14. FATHER'S NAME FIRST: BARTHOLOMEW | MIDDLE: | LAST: BRATTON | |
| 15. MOTHER'S MAIDEN NAME FIRST: ALMENA | MIDDLE: | LAST: DICE | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES): | 16b. SOCIAL SECURITY NO.: 218-30-2583 | 17. INFORMANT ADDRESS: JAMES M. COSTINETT/SON/SAME AS 13 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio pulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF: (b)
DUE TO, OR AS A CONSEQUENCE OF: (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from Nov. 1 19 88 to present 19 ____, that (I) (we) last saw the deceased alive on Dec 2 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/6/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOHN J. MERENDINO, M.D.

22e. ADDRESS: 4701 RANDOLPH RD #216 ROCKVILLE, MD

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: DEC 9,1988 | 23c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEMETERY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: BRENTWOOD PRINCE GEORGES MD |
| 24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901 | | 25a. DATE REC'D. BY REGISTRAR: DEC 12 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

015928 DEC 13 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

B B 3 7 0 1 6 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR | |
| Joseph | J. | Costinett | December 7, 1988 | 4:22 | P M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| Male | White | January 7, 1928 | 60 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Washington, DC | United States | | Montgomery County MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Silver Spring | Medlantic Manor of Layhill | Clerk-Publications | H. H. S. | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Montgomery | Rockville | YES ☐ NO ☒ | 14639 Bauer Drive / 20853 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Joseph | J. | Costinett | Margaret | | Blade |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 579-42-2701 | Margaret A. Stephens, | 4521 East West Highway Bethesda, MD 20814 |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Cancer of the Prostate

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I) (this hospital) attended the deceased from October 26, 19 88, to December 7, 19 88, that (I (we) last saw the deceased alive on December 3, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | 22c. DATE SIGNED |
|---|---|---|---|---|
| Joel H. Wilkerson, M.D. | | ATTENDING PHYSICIAN ☒ | MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | Dec. 7, 1988 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | |
| Joel H. Wilkerson, M. D. | | 650 Pennsylvania Avenue, SE, #420 Washington, DC 20003 | | |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Cremation | 12-9-88 | Baltimore-Washington Crem. | Laurel, Maryland |

| 24. FUNERAL DIRECTOR NAME ADDRESS | 26a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 | DEC 12 1988 | Julia Davidson-Lindsay |

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

Item#5 per FH film 648

FOR STATE REGISTRAR 2/2/89fj

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37017 REG. NO.

017755 DEC 30 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Lydia | Middle: MARIE | Last: CREEKMORE | 2a. DATE OF DEATH Month Day Year: 12-22-88 | 2b. HOUR: 1:51 PM |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH Month Day Year: March 27 1901 | 6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS | If under 1 year: Months / Days; If under 24 hrs.: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Kentucky | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH: Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Marketing Researcher | 12b. KIND OF BUSINESS OR INDUSTRY: Self-Employed | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: PG | 13c. CITY OR TOWN: Bowie | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 13435 Yorktown Dr. 20715 |
| 14. FATHER'S NAME First: William | Middle: A. | Last: Hood | 15. MOTHER'S MAIDEN NAME First: Laura | Middle: | Last: Savage |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): N/A | 16b. SOCIAL SECURITY NO.: 226-22-3505 | 17. INFORMANT ADDRESS: Iva Wells 505 Ellington Ct., Ashland, Ky. | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary Arrest — Approximate interval between onset and death: < 24 hours

DUE TO, OR AS A CONSEQUENCE OF (b): Sepsis

Conditions, if any, which gove rise to immediate couse (a), stating the underlying couse last

DUE TO, OR AS A CONSEQUENCE OF (c): Aspiration Pneumonia

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from Dec 21 19 88 to Dec 22 19 88, that (I) (we) last saw the deceased alive on Dec 22 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: William Fullner MD | DEGREE: M.D., ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ | 22c. DATE SIGNED: 12/23/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): William W. Fullner, MD | 22e. ADDRESS: 11251 Lockwood Drive, Silver Spring, Md | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/29/88 | 23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Burial Park | 23d. LOCATION CITY OR TOWN: Ashland / COUNTY: Boyd Co. / STATE: Ky. | |
| 24. FUNERAL DIRECTOR NAME AND ADDRESS: Ives-Pearson Funeral Home 2847 Wilson Blvd., Arlington, Va. 22201 | | 25a. DATE REC'D. BY REGISTRAR: DEC 29 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall | |

BP

DHMH - 1650M 1/81 (VRA 15, 4)

017735 DEC 30 88

1a FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37018 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | MILDRED / M. / CRESSMAN | 2a. DATE OF DEATH MONTH DAY YEAR | DECEMBER 8, 1988 | 2b. HOUR | 10:00 PM |
| 3. SEX | FEMALE | 4. RACE | CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR | AUGUST 23, 1918 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 70 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | INDIANA | 7b. CITIZEN OF WHAT COUNTRY? | UNITED STATES | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH | WHEATON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | RANDOLPH HILLS NURSING HOME | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | HOMEMAKER |
| 12b. KIND OF BUSINESS OR INDUSTRY | OWN HOME | | | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MARYLAND | MONTGOMERY | WHEATON | YES [ ] NO [X] | 12500 FELDON STREET, 20906 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| WILLIAM / B. / FARNEY | BESSIE / LOCHENOUR |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| NO | 315-10-7964 | WILMER H. CRESSMAN, 12500 FELDON STREET, WHEATON, MARYLAND 20906 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) METASTATIC LUNG CANCER — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MONTHS

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from AUGUST 25, 19 87, to DECEMBER 8, 19 88, that (I) (we) last saw the deceased alive on NOVEMBER 21, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Barry Hecht | ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | DECEMBER 9, 1988 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| BARRY HECHT, MD | 3941 FERRARA DRIVE, WHEATON, MARYLAND 20906 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 1988 DECEMBER 13, | ARLINGTON NATIONAL CEMETERY | ARLINGTON, VIRGINIA |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| ROBERT A. PUMPHREY FUNERAL HOME, INC. ROCKVILLE, 300 WEST MONTGOMERY AVENUE, ROCKVILLE, MD 20850 | DEC 9 '88 | Julia Davidson-Randall |

BP

DHMH - 1650M 1/81 (VRA 15, 4)

018471 JAN 0 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

88 037019 REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Louise; MIDDLE; LAST Cromwell
2a. DATE OF DEATH: KNOWN XX ESTIMATED ☐ MONTH 12 DAY 9 YEAR 88
2b. HOUR: M
3. SEX: Female
4. RACE: Black
5. DATE OF BIRTH: MONTH Oct. DAY 10 YEAR 1938
6. AGE (IN YEARS LAST BIRTHDAY): 50 YRS.
IF UNDER 1 YR.: MONTHS; DAYS
IF UNDER 24 HRS.: HOURS; MIN
2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 9 YEAR 88 19
2d. HOUR: 8:35A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): South Carolina
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED XX
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.
10. CITY OR TOWN OF DEATH: Potomac
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 9624 Willow Valley Drive
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housekeeper
12b. KIND OF BUSINESS OR INDUSTRY: Private

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: None
13b. COUNTY: None
13c. CITY OR TOWN: Wash., D. C.
13d. INSIDE CITY LIMITS? YES XX NO ☐
13e. STREET ADDRESS: 1203 7th St., NW 9999

14. FATHER'S NAME: FIRST Ellis; MIDDLE; LAST Verdell
15. MOTHER'S MAIDEN NAME: FIRST Luellen; MIDDLE; LAST Carter
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 247 70 8422
17. INFORMANT: Myra Carter(Daughter) ADDRESS: 1203 7th St., NW Washington, D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?:
20. AUTOPSY? YES XX NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH:
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19:
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2):
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐:
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.):
21f. LOCATION STREET; CITY OR TOWN; COUNTY; STATE:

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE OF M.D. MEDICAL EXAMINER: Charles P. Kokes
TITLE (SPECIFY): Acting Deputy Chief
DATE SIGNED: 12-10-88

VC EXAMINER'S NAME (TYPE OR PRINT): Charles P. KOkes, M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 12-15-88
23c. NAME OF CEMETERY OR CREMATORY: Wash. National Cemetery
23d. LOCATION CITY OR TOWN; COUNTY; STATE: Suitland, (PG) Maryland

24. FUNERAL DIRECTOR NAME: W. W. Chambers Co., ADDRESS: 517 11th St., SE, Wash., D. C.
25a. DATE RECD. BY REGISTRAR: DEC 19 88
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH - 97
(VR A15 ME (5))

019027 JAN 13 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 37020

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Lula | Middle: L | Last: Cromwell | 2a. DATE OF DEATH Month/Day/Year: 12-25-88 | 2b. HOUR: 1427 M | |
| 3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH Month/Day/Year: 08 01 04 | 6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS. | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD. | | |
| 10. CITY OR TOWN OF DEATH: Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SHADY GROVE ADVENTIST HOSP | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): School Teacher | 12b. KIND OF BUSINESS OR INDUSTRY: Public Schools | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD | 13b. COUNTY: Montgomery | 13c. CITY OR TOWN: Gaithersburg | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 401 Russell Ave Apt 516 Zip: 20877 | |
| 14. FATHER'S NAME First: Stephen | Middle: L. | Last: LeCompte | 15. MOTHER'S MAIDEN NAME First: Ida | Middle: May | Last: Jones |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): - | 16b. SOCIAL SECURITY NO.: 212643366 | 17. INFORMANT: Rev. G. Custer Cromwell, Husband, | ADDRESS: Same as #13 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 hours

DUE TO, OR AS A CONSEQUENCE OF

(b): Arteriosclerosis — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c): —

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Diabetes Mellitus, Cerebral arteriosclerosis with CBS.

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from Nov 3, 19 88, to Dec 25, 19 88, that (I) (we) last saw the deceased alive on Nov 10, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: James R. Moore Jr. | DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12-25-88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): James R. Moore Jr. | 22e. ADDRESS: 207 Brookes Ave Gaithersburg Md. | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: December 28, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: Rockville Cemetery | 23d. LOCATION CITY OR TOWN: Rockville | COUNTY / STATE: Maryland |
| 24. FUNERAL DIRECTOR NAME AND ADDRESS: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 W. Montgomery Avenue, Rockville, MD. 20850 | | 25a. DATE REC'D BY REGISTRAR: DEC 28 88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rondeau | |

BP 2

DHMH - 16 50M 1/81 (VRA 15, 4)

016545 DEC 19 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37021
REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Richard | Middle: S. | Last: Crowder | 2a. DATE OF DEATH Month-Day-Year: 12-3-88 | 2b. HOUR: 1:50 PM | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH Month-Day-Year: 2-16-03 | 6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS. | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): ILL. | 7b. CITIZEN OF WHAT COUNTRY?: USA. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH: SILVERSPG | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSP | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RET. OFFICER | 12b. KIND OF BUSINESS OR INDUSTRY: U.S. ARMY | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Md. | MONTGOMERY | SILVER SPRING | YES ☒ NO ☐ | 604 BLICK DR. 20904 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last |
|---|---|
| JAMES L. CROWDER | JENNIE PLATT |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| YES | WWII&KOREAN | 571-03-5790 | MARIAN G. CROWDER | 20567 SHADYSIDE WAY GERMANTOWN, Md. 20874 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiopulmonary arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1
DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF (c) cardiac arrhythmias
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☑ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 11-29, 19 88, to 12-3-19 88, that (I) (we) last saw the deceased alive on 12-3-19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE / DEGREE | ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN | 22c. DATE SIGNED |
|---|---|---|
| K. Sudhakar, M.D | ☐ ☑ ☐ | 12-4-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| S. SUDHAKAR | 500 EDMONSTON DR, ROCKVILLE, MD. 20851-2 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| CREMATION | 12-5-1988 | CHAMBERS CREMATORY | RIVERDALE, P.G.C. Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| W. W. CHAMBERS CO. INC. | SILVER SPRING, Md. 20910 | DEC 6 '88 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

017056 DEC 22 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 37022

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | Florence | Vietta | Crumley | 2a. DATE OF DEATH MONTH DAY YEAR | Dec 16 1988 |
| | | | | 2b. HOUR | 1:15 AM |
| 3. SEX | Female | | | | |
| 4. RACE | White | | | | |
| 5. DATE OF BIRTH MONTH DAY YEAR | November 7, 1905 | | | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 83 YRS. | | | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Massachusetts | | | | |
| 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. | | | | |
| 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | | | | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH | Silver Spring | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Fairland Nursing Home | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | Home |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Silver Spring | YES ☒ NO ☐ | 13012 Raintree Terrace 20904 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Walter / Sterling | Florence / Parrot |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 193-24-7518 | Robert Rich | same as above |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) SEPSIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b) DIABETES

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Kundan MD | M.D. | ATTENDING PHYSICIAN ☐ | MEDICAL DIRECTOR ☐ | STAFF PHYSICIAN ☐ | |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| A. Kundan | 8317 Cheany Lane, Laurel, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec 19, 1988 | Greenmount Cemetery | Philadelphia Penn. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE RECD. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Donaldson Funeral Home P.A. | Laurel, Maryland | DEC 22 1988 | Jutta Davidson-Kendall |

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

017498 DEC 28 88

1- FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

88 37023
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon poppers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: MICHAEL; MIDDLE: ; LAST: CRYSTAL | | 2a. DATE OF DEATH MONTH DAY YEAR: 12-17-88 | 2b. HOUR: 12:00 PM |
| 3. SEX: MALE | 4. RACE: CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR: May 30, 1908 | 6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Poland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD. |
| 10. CITY OR TOWN OF DEATH: Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 5225 Pooks Hill Rd., #1815N | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Business Owner | 12b. KIND OF BUSINESS OR INDUSTRY: Grocery |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Bethesda | YES ☐ NO ☐ | 5225 Pooks Hll Raod, #1815N (20814) |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Joseph / / Kristal | Rachel / / Fleischer |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | 17. INFORMANT ADDRESS |
|---|---|---|
| Yes | WWII | 116-22-3317 | Ross Crystal; Son; 5225 Pooks Hill Rd., #1818N Bethesda, Md. 20814 |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CARDIAC ARREST | 5 MIN |
| DUE TO, OR AS A CONSEQUENCE OF (b) | ARTERIOSCLEROTIC HEART DIS. | 10 YRS |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cholecystitis

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☑ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | | |

22a. I certify that (I) (this hospital) attended the deceased from 12-16 19 88 to 12-17 19 88, that (I) (we) last saw the deceased alive on 12-16 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Lewis H. Biben | ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/17/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Lewis H. Biben, MD | 1145 19th St. NW Washington, DC |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12/19/88 | Mt. Hebrew Cemetery | Flushing, New York |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852 | DEC 22 1988 | Julia Davidson-Randall |

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

019028 JAN 13 89

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 37024

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: MARY O. CUMBERPATCH | | | | 2a. DATE OF DEATH MONTH DAY YEAR: DECEMBER 22 1988 | 2b. HOUR: 10:45 P M |
| 3. SEX: FEMALE | 4. RACE: CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR: JANUARY 18 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD | |
| 10. CITY OR TOWN OF DEATH: BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER | 12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND | 13b. COUNTY: MONTGOMERY | 13c. CITY OR TOWN: KENSINGTON | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET ADDRESS: 9620 GLENCREST LANE 20895 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST: JAMES OGILVIE SHUMATE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: MARY EDNA WRIGHT | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES): - | 16b. SOCIAL SECURITY NO.: 508-28-7276 | | 17. INFORMANT ADDRESS: JAMES R.CUMBERPATCH,9620 GLENCREST LANE, KENSINGTON, MD 20895 | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): COLON CANCER

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 18, 19 88, to DECEMBER 22, 19 88, that (I) (we) last saw the deceased alive on DECEMBER 22, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: J. A. Butler | DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED: 23 Dec 88 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): J.A.BUTLER, LCDR, MC, USN | 22e. ADDRESS: NAVAL HOSPITAL BETHESDA, MD 20814-5011 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: DECEMBER 27, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEM. | 23d. LOCATION CITY OR TOWN: SILVER SPRING | COUNTY STATE: MARYLAND |
| 24. FUNERAL DIRECTOR NAME: ROBERT A. PUMPHREY FUNERAL HOME/ BETHESDA-CHEVY CHASE, INC. 7557 WISCONSIN AVENUE, BETHESDA, MARYLAND 20814 | | 25a. DATE REC'D. BY REGISTRAR: DEC 28 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson | |

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

018967 JAN 13 89

1. FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 37025

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Department of Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is answered or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Moody | Middle: Washington | Last: Cummings | 2a. DATE OF DEATH Month/Day/Year: December 27, 1988 | 2b. HOUR: 11:07 AM |
| 3. SEX: Male | 4. RACE: WHITE | 5. DATE OF BIRTH Month/Day/Year: 2/ 14/ 1898 | 6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS. | IF UNDER 1 YEAR Months/Days; IF UNDER 24 HRS. Hours/Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Tennessee | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY County MD. | |
| 10. CITY OR TOWN OF DEATH: Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Photographer | 12b. KIND OF BUSINESS OR INDUSTRY: Civil Service | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD | 13b. COUNTY: Montgomery | 13c. CITY OR TOWN: Olney | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 11800 Ethelwood Terrace 20832 |
| 14. FATHER'S NAME First: George | Middle: Washington | Last: Cummings | 15. MOTHER'S MAIDEN NAME First: Martha | Middle | Last: Brown |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 577-58-1752 | 17. INFORMANT: Mardel J. Shifflet | ADDRESS: Same as #13 |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12/27/88

DUE TO, OR AS A CONSEQUENCE OF

(b): Acute Myocardial Infarction — 12/9/88

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/9/88, 19____, to 12/27/88, 19____, that (I) (we) last saw the deceased alive on 12/27, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Robert L. Gold MD | DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12/27/88 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Robert L. Gold MD | 22e. ADDRESS | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL: BURIAL | 23b. DATE: Dec. 30, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: HILLCREST CEM. | 23d. LOCATION CITY OR TOWN: ANNAPOLIS COUNTY: A.A. MD. | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: Taylor Funeral Chapel Annapolis, Md. | | 25a. DATE REC'D. BY REGISTRAR: DEC 29 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

BPS 30

DHMH - 16 50M 1/81 (VRA 15, 4)

016210 DEC 15 88

FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

REG. NO. 88 37026

| 1. DECEASED NAME (TYPE OR PRINT) First / Middle / Last | 2a. DATE OF DEATH Month / Day / Year | 2b. HOUR |
|---|---|---|
| ABRAHAM J. DANIELS | 12/1/88 | 2:55 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH Month / Day / Year | 6. AGE (IN YEARS LAST BIRTHDAY) | If under 1 year: Months / Days | If under 24 hrs: Hours / Min. |
|---|---|---|---|---|---|
| Male | Caucasian | March 13, 1894 | 94 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Greece | U.S.A. | MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | Montgomery County, MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Silver Spring | Holy Cross Hospital | Civil Engineer | Bridge Aut Tri-Borough |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Silver Spring | YES ☒ NO ☐ | 1316 Fenwick Lane, #1203 20910 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last |
|---|---|
| Jeremiah Daniels | Rachel Abdala |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | -------- | 071-20-5630 | Raphael Daniels;Son; | 4700 Falstone Ave.; Chevy Chase, Md.20815 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY Hour A.M. P.M. / Month / Day / Year 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| ☐ | | |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION Street / City or Town / County / State |
|---|---|---|
| WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | | |

22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY, 19 88, to DECEMBER 1, 19 88, that (I) (we) last saw the deceased alive on DECEMBER 1 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN | 22c. DATE SIGNED |
|---|---|---|---|
| Hubert J. Alpert | M.D. | ☐ ☒ ☐ | 12/1/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| HUBERT J. ALPERT, M.D. | 8630 FENTON ST. SILVER SPRING, MD 20910 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION City or Town / County / State |
|---|---|---|---|
| Burial | 12/4/88 | Cedar Park Cemetery | Paramus, New Jersey |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike;Rockville, Md. 20852 | DEC 6 1988 | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

017736 DEC 30

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR — REG. NO. 37027

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Meredyth | MIDDLE: Anne | LAST: Dasburg | 2a. DATE KNOWN OF DEATH XX / ESTIMATED ☐ MONTH DAY YEAR: 12-9-88 | 2b. HOUR: M | | | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Nov. 6, 1982 | 6. AGE (IN YEARS LAST BIRTHDAY): 6 YRS. | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 12-9-88 19 | 2d. HOUR: 3:30P M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington,D.C. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD | | | | |
| 10. CITY OR TOWN OF DEATH: Potomac | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Bradley Blvd & Kentsdale Road | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Student | 12b. KIND OF BUSINESS OR INDUSTRY: School | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD | 13b. COUNTY: Montgomery | 13c. CITY OR TOWN: Potomac | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 10609 Alloway Drive/20854 | | | |
| 14. FATHER'S NAME FIRST: John | MIDDLE: H. | LAST: Dasburg | 15. MOTHER'S MAIDEN NAME FIRST: Mary | MIDDLE: Lou | LAST: Diaz | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): --- | 16b. SOCIAL SECURITY NO.: 220-02-9393 | 17. INFORMANT ADDRESS: John H. Dasburg, Same address as #13. | | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:

8129

Conditions, if any, which gove rise to immediate couse (a) stating the underlying couse last.

(a) IMMEDIATE CAUSE: Head injuries

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES XX NO ☐ |
| 21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: 3:15PM 12-9-88 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Occupant in van/multi-vehicle impacts |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): road | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE: Bradley Blvd. & Kentsdale Road, Montgomery County,MD |

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE OF M.D. _____ TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER — DATE SIGNED 12-10-88

VC EXAMINER'S NAME (TYPE OR PRINT) Charles P. KOkes,M.D. ADDRESS 111 Penn Street,Baltimore,MD 21201

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Burial | 12/12/88 | St. Gabriel's Cemetery | Potomac, MD |

24. FUNERAL DIRECTOR NAME / ADDRESS: Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave,NW,Washington,D.C. 20016

25a. DATE REC'D BY REGISTRAR: DEC 14 88

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

018557 JAN -9 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37023
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: LENA | MIDDLE: G. | LAST: DAVIS | 2a. DATE OF DEATH MONTH DAY YEAR: December 25, 1988 | 2b. HOUR: 4:20 AM | |
| 3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: Sept. 16, 1898 | 6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH: Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 10301 Grosvenor Pl. #L08 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Home | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Montgomery | 13c. CITY OR TOWN: Bethesda | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 10301 Grosvenor Pl#L08(20814) | |
| 14. FATHER'S NAME FIRST: Mendel | MIDDLE | LAST: Greenwald | 15. MOTHER'S MAIDEN NAME FIRST: Rose | MIDDLE | LAST: Greenwald |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES): ---------- | 16b. SOCIAL SECURITY NO.: 070-32-3290 | 17. INFORMANT: Marion S. Maillard; Daughter; | ADDRESS: Place, #L08; Bethesda, Md. 10301 Grosvenor | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio Pulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 mins

DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Congestive heart failure

DUE TO, OR AS A CONSEQUENCE OF (c): Coronary Artery Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic Obstructive Pulmonary Disease

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from Dec 88 to May 80 (19) to Dec 25 88 (19), that (I) (we) last saw the deceased alive on Dec 88 (19), and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Howard Goldstein DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/25/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Howard Goldstein, MD

22e. ADDRESS: 4701 Randolph Rd #105: Rockville, Md

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/28/88 | 23c. NAME OF CEMETERY OR CREMATORY: Mt. Hebron Cemetery | 23d. LOCATION CITY OR TOWN: Flushing | COUNTY / STATE: N.Y. |

24. FUNERAL DIRECTOR NAME: DANZANSKY-GOLDBERG MEMORIAL CHAPELS
ADDRESS: 1170 Rockville Pike: Rockville, Md 20852

25a. DATE REC'D. BY REGISTRAR: JAN 04 1989

25b. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall

BP____

DHMH - 16 50M 1/81 (VRA 15, 4)

016228 DEC 15188 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37023 REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Lillian | Hicks | Davis | November 24, 1988 | 8:07 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH Month Day Year | 6. AGE (IN YEARS LAST BIRTHDAY) | If under 1 year: Months / Days | If under 24 hrs: Hours / Min. |
|---|---|---|---|---|---|
| Female | Caucasian | February 19, 1897 | 91 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Maryland | United States | MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | Montgomery County, MD |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Potomac | 8508 Buckhannon Drive | Homemaker | Own Home |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Delaware | Sussex | Rehobeth Beach | YES ☒ NO ☐ | 105 St. Lawrence Street/19971 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Samuel | | Hicks | Josie | | Usselton |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | | 215-38-0946 | John E. Davis, Jr., Son, 8508 Buckhannon Drive, Potomac, Maryland 20854 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | Approximate interval between onset and death |
|---|---|---|
| IMMEDIATE CAUSE (a) | CONGESTIVE HEART FAILURE | 2 MONTHS |
| DUE TO, OR AS A CONSEQUENCE OF (b) | ARTERIOSCLEROTIC HEART DISEASE | 5 YEARS |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CARCINOMA OF BREAST (RT.)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from NOV. 1, 19 87, to NOV 24, 19 88, that (I) (we) last saw the deceased alive on NOV. 23, 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Robert C. Custer M.D. | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | Nov. 25, 1988 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Robert C. Custer, M.D. | 5153 Westbard Avenue, Bethesda, MD 20816 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Nov. 29, 1988 | Chester Cemetery | Chestertown, Maryland |

| 24. FUNERAL DIRECTOR NAME AND ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Robert A. Pumphrey Funeral Home Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 | NOV 29 1988 | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

18268 JAN -6 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

REG. NO. 88 37030

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Sudie MIDDLE: Britt LAST: Davis | | | | 2a. DATE OF DEATH MONTH DAY YEAR: 12 28 88 | 2b. HOUR: 2210 M |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: 04 03 05 | 6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH: Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Germantown | YES ☐ NO ☒ | 20213 Laurel Hill Way / 20874 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| John | B. | Britt | Margaret | Estelle | Ingram |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | | 239-28-9655 | Betsy Algire, Same as 13 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiac Arrest | 5 minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Respiratory Failure | 1 hour |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Lung Carcinoma | 2 months. |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Gastrointestinal Bleeding, Small Bowel Obstruction

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from December 19 19 88, to December 28 19 88, that (I) (we) last saw the deceased alive on December 28 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN | 22c. DATE SIGNED |
|---|---|---|---|
| Wayne L. Meyer MD | MD | ☐ ☒ ☐ | 12/29/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Wayne L. Meyer | 9715 Medical Center Drive #214, Rockville, MD 20850 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | 12-30-88 | Suburban Crematory | Silver Spring, Maryland |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, Maryland 20910 | JAN 04 1989 | Gina Wilson-Randall |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0184701 JAN -3 89

FOR STATE REGISTRAR

REG. NO. 88 37031

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
| LYNNE | R | DAY | DECEMBER 15 1988 | 6:10P M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | # UNDER 1 YEAR: MONTHS / DAYS; # UNDER 24 HRS: HOURS / MIN. |
| Female | Caucasian | JUNE 18 1938 | 50 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Washington, D.C. | United States | | MONTGOMERY COUNTY, MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| OLNEY | MONTGOMERY GENERAL HOSPITAL | Principal Administrative Aide | Montgomery County Gov't. | |
| 9. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| MD | Montgomery | Gaithersburg | YES ☒ NO ☐ | 448 Girard Street, #202 Zip: 20877 |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | | |
| Everett J. Russell | | Mervale Bond | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | |
| No | - | 217-34-0871 | Mr. Everett J. Russell, Father, 15143 Vantage Hill Road, Silver Spring, MD. | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Metastatic Cancer Breast — 2 years

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Septicemia

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from Dec 5, 19 1988, to Dec 15, 19 88, that (I) (we) last saw the deceased alive on Dec 15, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 12/15/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis A. Kellert, MD — 22e. ADDRESS 4000 Olney Laytonsville Rd, Olney, Md 20832

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | December 19, 1988 | Monocacy Cemetery | Beallsville, Maryland |

24. FUNERAL DIRECTOR NAME / ADDRESS: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland

25a. DATE REC'D. BY REGISTRAR: DEC 19 1988

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

018469 JAN 1989

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37032 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Mary | Middle: Katherine | Last: Dean | 2a. DATE OF DEATH Month/Day/Year: Dec 15, 1988 | 2b. HOUR: 903 AM | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH Month/Day/Year: March 17, 1923 | 6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS. | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD | | |
| 10. CITY OR TOWN OF DEATH: Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home | | |

**USUAL RESIDENCE** (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Kensington | YES [X] NO [ ] | 5308 Flanders Avenue 20895 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last |
|---|---|
| William J. Lauck | Katherine Noonan |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| NO | 579-09-3527 | Vincent Joseph Dean same as # 13 |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: immediate

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): chronic and acute renal failure

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 12/14/88 | acute renal failure | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY Hour A.M. P.M. / Month / Day / Year 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION Street / City or Town / County / State |
|---|---|---|
| WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | | |

22a. I certify that (I) (this hospital) attended the deceased from July 1 19 88 to Dec. 15 19 88, that (I) (we) last saw the deceased alive on Dec 15 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 12/15/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): G. Peter Pishkas

22e. ADDRESS: 11510 Old Georgetown Rd. Rockville

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION City or Town / County / State |
|---|---|---|---|
| BURIAL | Dec. 17, 1988 | Gate of Heaven Cem. | Silver Spring, Maryland |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25. DATE RECEIVED BY REGISTRAR | 25. REGISTRAR'S SIGNATURE |
|---|---|---|
| DeVol Funeral Home 2222 Wisc. Ave. NW Wash. DC | DEC 22 88 | Gisha Davidson-Randall |

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

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017150 DEC 27 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 037033 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: ELENA — MIDDLE: DEL — LAST: BALZO
2a. DATE OF DEATH — MONTH DAY YEAR: 12/20/88
2b. HOUR: 1:45PM
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH — MO DAY YEAR: 08/27/03
6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): ITALY
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY — MD
10. CITY OR TOWN OF DEATH: SILVER SPRING
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS): SYLVAN MANOR HEALTH CENTER
12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): HOUSEWIFE
12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE: MD — COUNTY: FREDERICK — CITY OR TOWN: MT. AIRY
13a. INSIDE CITY LIMITS? YES ☐ NO ☐
13b. STREET ADDRESS: 12415 CATOCTIN VIEW RD. 21771

14. FATHER'S NAME — FIRST MIDDLE LAST: UNKNOWN
15. MOTHER'S MAIDEN NAME — FIRST MIDDLE LAST: UNKNOWN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES): NONE
16b. SOCIAL SECURITY NO.: 081-26-4379
17. INFORMANT — ADDRESS: PASQUALE L. DEL BALZO 4908 BALTIC AVE. ROCKVILLE, MD

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): UNKNOWN
DUE TO, OR AS A CONSEQUENCE OF (b): OLD AGE
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 48 hr

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/17 19 88 to 12/20 19 88, that (I) (we) last saw the deceased alive on 12/20 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Myron L Lenkin — DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/20/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): MYRON L. LENKIN
22e. ADDRESS: 2309 SHOREFIELD WHEATON MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: 12/23/88
23c. NAME OF CEMETERY OR CREMATORY: ST. RAYMOND'S CEMETERY
23d. LOCATION — CITY OR TOWN: BRONX — STATE: NEW YORK

24. FUNERAL DIRECTOR (NAME): D. HARTZLER — ADDRESS: LIBERTYTOWN, MD
25a. DATE REC'D BY REGISTRAR: DEC 23 1988
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

17753 DEC 30 88

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 37034

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH | DAY | YEAR | 2b. HOUR |
|---|---|---|---|---|---|---|
| FREDA | L. | DENNIBERG | DECEMBER | 23 | 1988 | 5:35A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | FEBRUARY 21, 1907 | 81 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| RUSSIA | U. S. A. | MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | MONTGOMERY COUNTY MD |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| WHEATON | RANDOLPH HILLS NURSING HOME | HOUSEWIFE | OWN HOME |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MARYLAND | MONTGOMERY | BETHESDA | YES ☒ NO ☐ | 5225 POOKS HILL ROAD 20814 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| HARRY | | LEVINSON | BESSIE | | ISKOVITCH |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 577 07 3549 | ELLIOT P. DENNIBERG, | 11916 RIVER ROAD POTOMAC, MARYLAND |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Respiratory Failure d/t COPD | 1 week |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Widespread Oat Cell Carcinoma of the Lung | 8 months |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from Dec 15 19 88 to Dec 23 19 88, that (I) (we) last saw the deceased alive on Dec 16 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/23/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DR. JOHN A. GALOTTO, M. D. | 5225 POOKS HILL ROAD SUITE NO. 1 BETHESDA, MARYLAND |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 12/26/1988 | KING DAVID MEMORIAL GARDEN | FALLS CHURCH, VIRGINIA |

| 24. NAME AND ADDRESS OF FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME | 232 CARROLL STREET, N. W., WASHINGTON, D. C. | DEC 29 1988 | Sheila Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

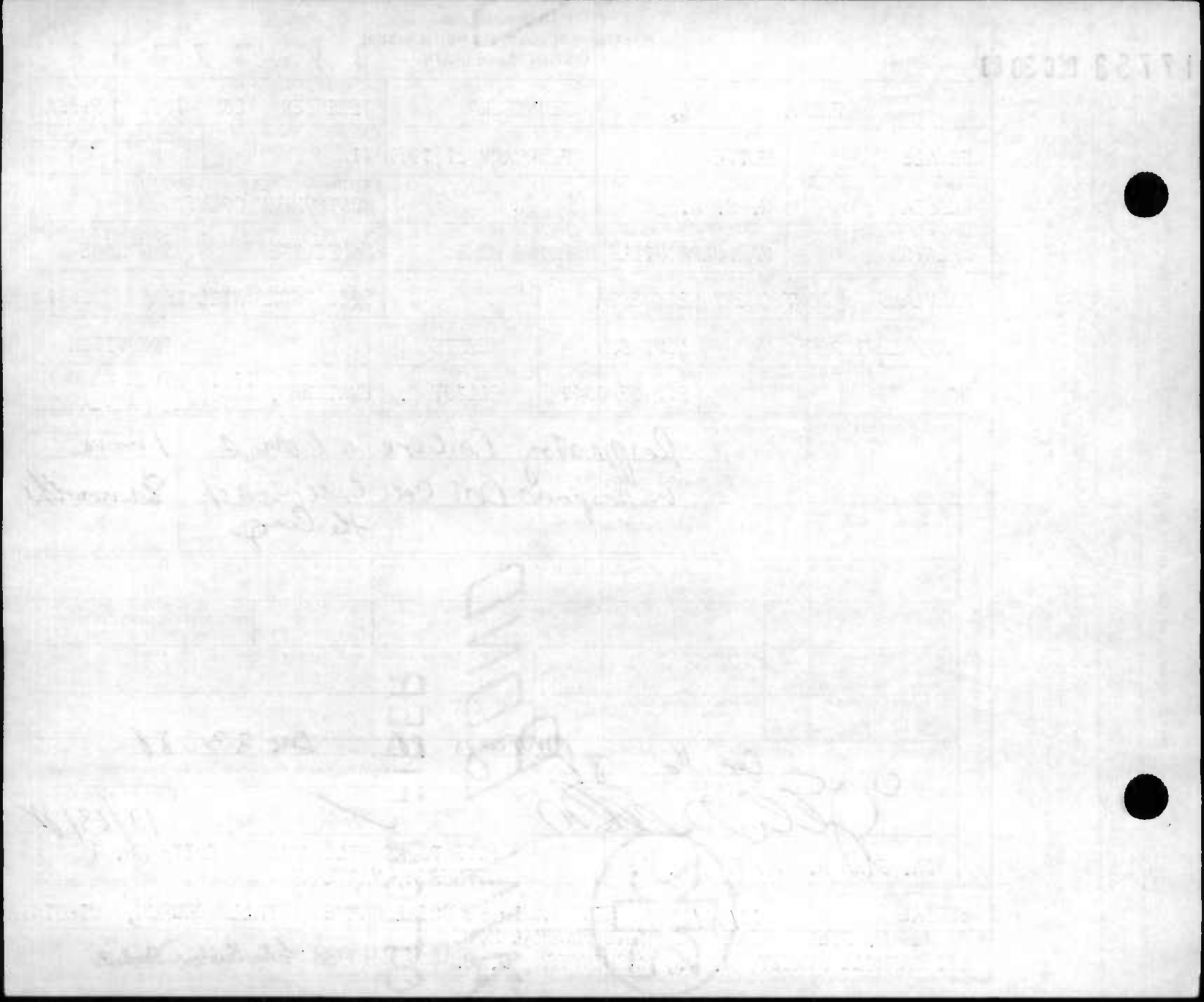
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DMMH - 16 50M 4/83
(VRA 15, 4)



017737 DEC 30 88 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 37035
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Gladys | MIDDLE: Davis | LAST: Dennis | 2a. DATE OF DEATH MONTH: Dec. | DAY: 7 | YEAR: 1988 |
| 2b. HOUR: 6:15 P M | | | | | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH: Apr. DAY: 30, YEAR: 1891 | 6. AGE (IN YEARS LAST BIRTHDAY): 97 YRS. | IF UNDER 1 YEAR MONTHS: DAYS: | IF UNDER 24 HRS. HOURS: MIN.: |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH: Chevy Chase | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Bethesda Retirement Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD | 13b. COUNTY: Montg. | 13c. CITY OR TOWN: Chevy Chase | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 6411 Highland Dr./20815 | |
| 14. FATHER'S NAME FIRST: Henry | MIDDLE: R. | LAST: Davis | 15. MOTHER'S MAIDEN NAME FIRST: Helen | MIDDLE: -- | LAST: Rogers |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): -- | 16b. SOCIAL SECURITY NO.: 199-28-6555 | 17. INFORMANT: Dorothy D. Orem, Same address as #13. | ADDRESS: | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral infarct — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 72 hrs
DUE TO, OR AS A CONSEQUENCE OF: (b) Atherosclerotic Cardiovascular Disease — 10 years plus
DUE TO, OR AS A CONSEQUENCE OF: (c) with Chronic Brain Syndrome
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Chronic non healing ulcer of left leg

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 8/22 19 87 to 12/7 19 88, that (I) (we) last saw the deceased alive on 11/30 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: Michel N Healy MD | DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12/8/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Michel N Healy MD | 22e. ADDRESS: 5652 Shields Drive Bethesda MD 20817 | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation | 23b. DATE: 12/8/88 | 23c. NAME OF CEMETERY OR CREMATORY: Mt. Comfort Crematory | 23d. LOCATION CITY OR TOWN: Alexandria, VA | COUNTY / STATE |
| 24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons, Inc. ADDRESS: 5130 Wisconsin Ave, NW, Washington, D.C. 20016 | 25a. DATE REC'D. BY REGISTRAR: DEC 9 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

017738 DEC 30 88

ITEM:16b per FH G-668
10-2-90 cm

1 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

88 37036
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | CARROLL M. DIAMOND | 2a. DATE OF DEATH MONTH / DAY / YEAR | 12 5 88 | 2b. HOUR 1747 M |
| 3. SEX | female | 4. RACE | white | 5. DATE OF BIRTH MONTH / DAY / YEAR: 12 31 1908 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 79 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | W.Va. | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Montgomery county MD. | | | |
| 10. CITY OR TOWN OF DEATH | Rockville, MD | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | SHADY GROVE ADVENTIST HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker |
| 12b. KIND OF BUSINESS OR INDUSTRY | own home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Maryland | 13b. COUNTY | Montgomery | 13c. CITY OR TOWN: Gaithersburg |
| 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS | 890 Clopper Road 20878 | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | Charles Mason Martin | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Marion Virginia Wilson | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | NO | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. 220-38-1540 ~~215-36-5177~~ | 17. INFORMANT ADDRESS: 7205 Lock Lomond Drive Douglas Diamond, Bethesda, MD 20817 |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) cardiogenic shock

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/2/88, 19__, to 12/5/88, 19__, that (I) (we) last saw the deceased alive on 12/5/88, 19__, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Pasqual Perinno | DEGREE MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ |
| 22c. DATE SIGNED | 12/5/88 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | Pasqual Perinno, M.D. | 22e. ADDRESS | 15225 Shady Grove Road Rockville, Maryland 20850 |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Burial | 23b. DATE | Dec.10,1988 | 23c. NAME OF CEMETERY OR CREMATORY: St. Rose of Lima |
| 23d. LOCATION CITY OR TOWN / COUNTY / STATE | Gaithersburg Maryland | | | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | De Vol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. | 25a. DATE REC'D. BY REGISTRAR | DEC 13 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

88 REG. NO. 37037

016676 DEC 20 88

1. DECEASED NAME (TYPE OR PRINT): FIRST PAUL; MIDDLE HERBERT; LAST DIBBLE
2a. DATE OF DEATH: MONTH DECEMBER; DAY 12; YEAR 1988
2b. HOUR: 2:05 PM
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: MONTH FEBRUARY; DAY 16; YEAR 1966
6. AGE (IN YEARS LAST BIRTHDAY): 22 YRS. IF UNDER 1 YEAR: MONTHS, DAYS. IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.
10. CITY OR TOWN OF DEATH: BETHESDA
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NIH, THE CLINICAL CENTER
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Communication Specialist
12b. KIND OF BUSINESS OR INDUSTRY: USAF

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: NEW YORK
13b. COUNTY: Genesee
13c. CITY OR TOWN: BATAVIA
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE: 9345 SHEPARD RD./ 14020

14. FATHER'S NAME: FIRST Stephen; MIDDLE; LAST Dibble
15. MOTHER'S MAIDEN NAME: FIRST Linda; MIDDLE; LAST Hummel
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): 1985-1988
16b. SOCIAL SECURITY NO.: 077-64-1492
17. INFORMANT ADDRESS: STEPHEN DIBBLE (SAME AS 13)

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute lymphoblastic lymphoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 months
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: RENAL insufficiency, PNEUMONIA, pancytopenia, COAGULOPATHY

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that XX (this hospital) attended the deceased from October 25, 19 88, to December 12, 19 88, that XX (we) last saw the deceased alive on December 12, 19 88, and that in XX (our) opinion death occurred on the date and hour and from the causes stated above, (he/we) (did) XXXX view the body after death.

22b. SIGNATURE: Peter Francis MD
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: December 12 88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Peter FRANCIS MD
22e. ADDRESS: National INstitutes of Health, 9000 Rockville PIke, Bethesda, Maryland 20892

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 12-15-88
23c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery
23d. LOCATION CITY OR TOWN: Batavia, COUNTY: New York, STATE:
24. FUNERAL DIRECTOR NAME: H. E. Turner & Co., Inc. ADDRESS: 403 East Main Street, Batavia, NY 14020
25a. DATE REC'D. BY REGISTRAR: DEC 19 1988
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1660M 2/84 (VRA 15, 4)

16559 DEC 19 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FORM 16 SOM 1/81 (VRA 15, 4)

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

1 - FOR STATE REGISTRAR

REG. NO 88 37033

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: ELIZABETH Middle: V. Last: DILLON | ELIZABETH. V. DILLON | | | 2a. DATE OF DEATH Month Day Year: 12 07 88 | 2b. HOUR: 1702 P M |
| 3. SEX: Female | 4. RACE: WHITE | 5. DATE OF BIRTH Month Day Year: Mar. 30 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS. | If under 1 year: Months / Days; If under 24 hrs.: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY | MD |
| 10. CITY OR TOWN OF DEATH: ROCKVILLE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hosp. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SECRETARY | 12b. KIND OF BUSINESS OR INDUSTRY: EDUCATION |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| WV | BERKELEY | HEDGESVILLE | YES ☐ NO ☒ | RT. 3, BOX 219 99999 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last |
|---|---|
| GILMORE VanFOSSEN | KATE STITELY |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 236-66-1835 | MRS. EVELYN KELLY | 11344 SW 1018TH ST, LAKE SUZY, FL 33821 |

**MEDICAL CERTIFICATION**

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 9-1, 19 87, to 12-7, 19 88, that (I) (~~was~~) lost saw the deceased alive on 12-1, 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| John Tauber | MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12-7-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| John Tauber | 8218 Wisconsin Ave Bethesda md |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 12/12/88 | HEDGESVILLE CEM. | HEDGESVILLE BERKELEY WV |

| 24. FUNERAL DIRECTOR AND ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Charles M. Brown BROWN FUNERAL HOME, POBOX 821, 327 W. KING ST. MARTINSBURG, WV | DEC 16 1988 | |

16533 DEC 1988

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 37039

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | Doris / M. / Dimmers | 2a. DATE OF DEATH MONTH DAY YEAR | December 3, 1988 |
| 2b. HOUR | 6:10 PM | | |
| 3. SEX | Female | 4. RACE | Caucasian |
| 5. DATE OF BIRTH MONTH DAY YEAR | December 26, 1912 | 6. AGE (IN YEARS LAST BIRTHDAY) | 75 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS: HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Massachusetts | 7b. CITIZEN OF WHAT COUNTRY? | United States |
| 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | | 9. BALTIMORE CITY OR COUNTY OF DEATH | Montgomery County, MD. |
| 10. CITY OR TOWN OF DEATH | Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Nursing Bethesda Retirement & Center |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY | Own home |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Maryland | 13b. COUNTY | Montgomery |
| 13c. CITY OR TOWN | Bethesda | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 8401 Irvington Avenue/20817 |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | Joseph / / Mulligan | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Mary / Margaret / Hoolihan |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | No | (IF YES, GIVE WAR OR DATES) | |
| 16b. SOCIAL SECURITY NO. | 148-12-9483 | 17. INFORMANT | Janet D. Spires |
| ADDRESS | 6721 North 19th Road Arlington, Virginia 22205 | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Renal Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 year

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Mellitus

DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) ~~XXXXXXX~~ attended the deceased from _____, 19 81, to December 3, 19 88, that (I) ~~XXX~~ last saw the deceased alive on December 2, 19 88, and that in (my) ~~XXX~~ opinion death occurred at the date and hour and from the causes stated above, (I) ~~XXXXXX~~ (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Robert F. Lindeman MD | DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: December 5, 1988 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | Robert Lindeman, M.D. | 22e. ADDRESS | 10215 Fernwood Road, Bethesda, Maryland 20817 |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Burial | 23b. DATE | December 6, 1988 |
| 23c. NAME OF CEMETERY OR CREMATORY | Gate of Heaven Cem. | 23d. LOCATION CITY OR TOWN / COUNTY / STATE | Bethesda/Montgomery/Maryland |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, MD 20814 | 25a. DATE REC'D. BY REGISTRAR | DEC 5 '88 |
| 25b. REGISTRAR'S SIGNATURE | Julia Davidson-Randall | | |

018467 JAN -9 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37040 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Alexander | MIDDLE | LAST: Djabadary | 2a. DATE OF DEATH MONTH: December | DAY: 10 | YEAR: 1988 | 2b. HOUR: 10:30 AM |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH: 1 | DAY: 18 | YEAR: 31 | 6. AGE (IN YEARS LAST BIRTHDAY): 57 YRS. | IF UNDER 1 YEAR MONTHS / DAYS; IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): GERMANY | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY CO. MD. | | | |
| 10. CITY OR TOWN OF DEATH: OLNEY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): EXECUTIVE-MANAGER-RET. | 12b. KIND OF BUSINESS OR INDUSTRY: AMEX. | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md. | 13b. COUNTY: MONTGOMERY | 13c. CITY OR TOWN: SILVER SPRING | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET ADDRESS: 2040 KINGSHOUSE RD. 20904 | | |
| 14. FATHER'S NAME FIRST: PRINCE | MIDDLE: GEORGE | LAST: DJABADARY | 15. MOTHER'S MAIDEN NAME FIRST: GERTRUDE | MIDDLE | LAST: ALEXANDER | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES | (IF YES, GIVE WAR OR DATES): 1952-1956 | 16b. SOCIAL SECURITY NO.: 074-32-6316 | 17. INFORMANT ADDRESS: ROSEMARIE DJABADARY (SAME AS ITEM #13) | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Extensive Lung Cancer
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR (A.M. / P.M.) MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/10/88 to 12/10/88, that (I) (we) last saw the deceased alive on 12/10/88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: M. Wajeed Khan, MD | DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED: 12/11/88 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. Khan | 22e. ADDRESS: 12102 Georgia Ave, Wheaton MD 20902 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION | 23b. DATE: 12-13-1988 | 23c. NAME OF CEMETERY OR CREMATORY: CHAMBERS CREMATORY | 23d. LOCATION CITY OR TOWN: RIVERDALE, | COUNTY: P.G.C. | STATE: Md. |
| 24. FUNERAL DIRECTOR NAME: W. W. CHAMBERS CO. INC. | ADDRESS: 20910 SILVER SPRING, MD. | DATE RECD. BY REGISTRAR: DEC 16 88 | 25. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

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DHMH - 16 50M 1/81 (VRA 15, 4)

017945 DEC -3 89 — FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

REG. NO 88 37041

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: HILDA | MIDDLE: C. | LAST: DOERR | 2a. DATE OF DEATH MONTH DAY YEAR: DECEMBER 25, 1988 | 2b. HOUR: 10:45 A M | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR: MARCH 3, 1908 | 6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ohio | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH: GAITHERSBURG | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WILSON HEALTH CARE CENTER | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ORGANIST | 12b. KIND OF BUSINESS OR INDUSTRY: CHURCH | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD. | 13b. COUNTY: MONT. | 13c. CITY OR TOWN: GAITHERSBURG | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 401 RUSSELL AVE. 20877 | |
| 14. FATHER'S NAME FIRST: WILLIAM | MIDDLE: - | LAST: DOERR | 15. MOTHER'S MAIDEN NAME FIRST: EMMA | MIDDLE: - | LAST: BACHER |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES | (IF YES, GIVE WAR OR DATES): WWII | 16b. SOCIAL SECURITY NO.: 279-26-4760 | 17. INFORMANT: DOROTHY FARMER | ADDRESS: 407 RUSSELL AVE. #301 GAITHERSBURG MD 20877 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Liver Cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b):
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Christopher Cranford MD — DEGREE: Covering for Dr. Medoff — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/25/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Christopher Cranford — 22e. ADDRESS: 615 West Montgomery Ave Rockville MD 20850

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: DEC. 30, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: OAKHILL CEMETERY | 23d. LOCATION CITY OR TOWN: GLENDALE | COUNTY: HAMILTON STATE: OHIO |
| 24. FUNERAL DIRECTOR NAME: MURIEL H. BARBER ADDRESS: LAYTONSVILLE, MD. 20879 | 25a. DATE REC'D BY REGISTRAR: DEC 30 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

0 1 7 7 3 9 DEC 30 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR Mary M. Donaldson — B B 3 7 0 4 2 REG. NO

1. DECEASED NAME (TYPE OR PRINT): FIRST MARY; MIDDLE; LAST DONALDSON
2a. DATE OF DEATH: MONTH DAY YEAR 12-13-88
2b. HOUR 12 15 P M
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: MONTH DAY YEAR Aug. 15, 1907
6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., DC
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Bethesda
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hosp.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife
12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: Mont.
13c. CITY OR TOWN: Bethesda
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS: 6032 Cheshire Dr. 20814

14. FATHER'S NAME: FIRST Henry; MIDDLE; LAST Cook Macatee
15. MOTHER'S MAIDEN NAME: FIRST Miniana; MIDDLE; LAST Paxton
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO. 217-48-4742
17. INFORMANT: Elizabeth P. Donaldson ADDRESS: 4518 Gladwyne Dr. Beth. MD 20814

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute respiratory failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO, OR AS A CONSEQUENCE OF: (b) Congestive heart failure — 10 days
DUE TO, OR AS A CONSEQUENCE OF: (c) Vaginal bleeding — 7 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Old age, Rheumatoid Arthritis

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from October 19 88 to 12-13 19 88, that (I) (we) last saw the deceased alive on 12-7 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE Morell DEGREE ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED 12-13-88
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EVA M. MORELL
22e. ADDRESS 6000 EXECUTIVE BLVD, ROCKVILLE MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation
23b. DATE
23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory
23d. LOCATION CITY OR TOWN Alexandria, VA COUNTY STATE
24. FUNERAL DIRECTOR (NAME) Joseph Gawler's Sons, Inc. (ADDRESS) 5130 WI Ave,. NW Wash., DC 20016
DATE RECD. BY REGISTRAR DEC 14 88 REGISTRAR'S SIGNATURE Gina Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

0 1 7 7 4 0 - DEC 30 08 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37043 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Felix | MIDDLE: I. | LAST: Drobinski | 2a. DATE OF DEATH MONTH DAY YEAR: December 10, 1988 | 2b. HOUR: 5:10 PM | |
| 3. SEX: Male | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: July 7, 1890 | 6. AGE (IN YEARS LAST BIRTHDAY): 98 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD. | | |
| 10. CITY OR TOWN OF DEATH: Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Collingswood Nursing Home | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Pharmacist | 12b. KIND OF BUSINESS OR INDUSTRY: Drug Store Owner | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Bethesda | YES ☐ NO ☒ | 9916 Julliard Drive/20817 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Ignatius | F. | Drobinski | Wladyslawa | | Zielinska |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WWI | 065-26-3559 | Frank E. Jablonski, Nephew, Same as #13 | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): coronary arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from July, 19 88, to Dec 10, 19 88, that (I) (we) last saw the deceased alive on Nov 25, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | 22c. DATE SIGNED |
|---|---|---|---|---|
| John F. Tauber | MD | ATTENDING PHYSICIAN ☒ | MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | Dec. 11, 1988 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| John F. Tauber, M.D. | 8218 Wisconsin Avenue, Bethesda, MD 20814 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec. 14, 1988 | St. Mary's Cemetery | Staten Island, New York |

24. FUNERAL DIRECTOR (NAME AND ADDRESS): Robert A. Pumphrey Funeral Home Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850

25. DATE RECEIVED BY REGISTRAR: DEC 12 88

25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

017408 DEC 28 88

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR — REG. NO. 88 037041

1. DECEASED NAME (TYPE OR PRINT): FIRST Lillian (Lillian) MIDDLE P. (P.) LAST DuCharme (DuCharme)

2a. DATE OF DEATH: MONTH 12 DAY 22 YEAR 88 — 2b. HOUR 5 10 PM

3. SEX: Female (Female)

4. RACE: White (white)

5. DATE OF BIRTH: MONTH 12 DAY 16 YEAR 92 — AGE (IN YEARS LAST BIRTHDAY) 96 (96 YRS.) — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Connecticut

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Olney

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Brooke Grove Nsg. Home

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Bookkeeper

12b. KIND OF BUSINESS OR INDUSTRY: Bookkeeping

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Conn — 13b. COUNTY: New London — 13c. CITY OR TOWN: Old Lyme — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS / ZIP CODE: 13 Town Woods Road 06371

14. FATHER'S NAME: FIRST Ogden MIDDLE Felix LAST Parrott

15. MOTHER'S MAIDEN NAME: FIRST Ellen MIDDLE LAST McCue

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 045-09-4258

17. INFORMANT: (daughter) Elaine D. Fowler — ADDRESS: 9404 Underwood St. Seabrook, MD 20706

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIO PULMONARY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10-MIN.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): DEHYDRATION — 1 WEEK

DUE TO, OR AS A CONSEQUENCE OF (c): CEREBRAL THROMBOSIS — 2 WEEKS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): MULTI-INFARCT DEMENTIA

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (~~the hospital~~) attended the deceased from DEC 5, 19 87, to DEC 22, 19 88, that (I) (~~we~~) last saw the deceased alive on DEC 19, 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (~~did not~~) view the body after death.

22b. SIGNATURE: Elvin Adams, M.D. — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED: 12-22-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ELVIN ADAMS, M.D.

22e. ADDRESS: 18430 Brooke Grove Rd., Olney, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 27 Dec 88

23c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery

23d. LOCATION: CITY OR TOWN New Haven, COUNTY Conn. STATE

24. FUNERAL DIRECTOR: NAME AND ADDRESS: Capitol Funeral Service, Falls Church, VA

25a. DATE REC'D BY REGISTRAR: DEC 27 1988

25b. REGISTRAR'S SIGNATURE: [signature]

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal from the state. If the medical examiner must be notified or the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

018466 JAN -9 89 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO. 37045

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be omitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Jean | MIDDLE: G | LAST: Dupuy | 2a. DATE OF DEATH MONTH DAY YEAR: 12 · 20 · 88 | 2b. HOUR: 4.15 A M | |
| 3. SEX: MALE | 4. RACE: CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR: JUNE 30 1899 | 6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): FRANCE | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH: SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): PHYSICIAN | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND | 13b. COUNTY: MONTGOMERY | 13c. CITY OR TOWN: SILVER SPRING | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET ADDRESS: 2201 COLSTON DR #T-202 20910 | |
| 14. FATHER'S NAME FIRST: AUGUST | MIDDLE | LAST: DUPUY-ALBREDE | 15. MOTHER'S MAIDEN NAME FIRST: MARIE-LOUISE | MIDDLE | LAST: ROGE' |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 145-14-0818 | 17. INFORMANT: SON JOHN L. DUPUY | ADDRESS: 20004 SWEET GUM CR GERMANTOWN, MD 20874 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from DEC 15, 19 88, to DEC 19, 19 88, that (I) (we) last saw the deceased alive on DEC 19, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Howard Goldberg | DEGREE: M D | ATTENDING PHYSICIAN ☑ / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12/20/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Howard Goldberg | | 22e. ADDRESS: 12012 Veirs Mill Road Wheaton MD | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: DEC 22, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEM. | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: SILVER SPRING MONTGOMERY MD |
| 24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901 | 25a. DATE REC'D BY REGISTRAR: DEC 23 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

BP 30

DHMH - 16 50M 1/81 (VRA 15, 4)

017741 DEC 30 88 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO 037046

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | Alice / B. / Dyson | 2a. DATE OF DEATH MONTH DAY YEAR | December 13 1988 | 2b. HOUR | 3:00 PM |
| 3. SEX | FEMALE | 4. RACE | CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR | MARCH 4 1899 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 89 YRS | IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY? | USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH | SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | MERIDIAN NURSING HOME | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | MEDICAL TECH |
| 12b. KIND OF BUSINESS OR INDUSTRY | EPISCOPAL HOSP | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | MARYLAND | 13b. COUNTY | MONTGOMERY | 13c. CITY OR TOWN | ROCKVILLE |
| 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | | 13e. STREET ADDRESS | 14808 WESTBURY ROAD 20853 | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | AMOS / / BASTOW | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | EMMA / / WIGHAM | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | NO | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | 202-30-7906 |
| 17. INFORMANT ADDRESS | ALYCE D. SCHMIDT/DAUGHTER/SAME AS 13 | | | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiorespiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 11 months

DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure

DUE TO, OR AS A CONSEQUENCE OF (c) Leukemia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 11-26- 19 88, to 12-13- 19 88, that (I) (we) last saw the deceased alive on 12-25- 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Krishna P. Kumar | DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12-13-88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | KRISHNA P. KUMAR | 22e. ADDRESS | 10802 Hickory Ridge Road |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | BURIAL | 23b. DATE | DEC 15, 1988 | 23c. NAME OF CEMETERY OR CREMATORY | CEDAR HILL CEMETERY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE | PHILADELPHIA PHILADELPHIA PA |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901 | 25a. DATE REC'D BY REGISTRAR | DEC 14 88 | 25b. REGISTRAR'S SIGNATURE | Julia Davidson-Randall | | |

018465 JAN -9 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37047 REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| ANNA | K. | EAGLER | DECEMBER 14, 1988 | 6:00P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN. |
|---|---|---|---|---|---|
| FEMALE | CAUCASIAN | 3 14 19 | 69 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| GERMANY | USA | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | MONTGOMERY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| SILVER SPRING | 412 DEERFIELD AVENUE | HOMEMAKER | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MARYLAND | MONTGOMERY | SILVER SPRING | YES [ ] NO [ ] | 412 DEERFIELD AVENUE 20910 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| MICHAEL | | WILD | EMMA | | EBEL |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 215-74-5772 | JOSEPH C. EAGLER/HUSBAND/SAME AS 13 | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARCINOMA OF BREAST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 15 years

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from June 6, 19 88, to Dec 14, 19 88, that (I) (we) last saw the deceased alive on October 14 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the couses stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| [signature] | MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] | 12/15/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| KIRKLAND C. BRASLE | 7600 CARROLL AVE, TAKOMA PARK MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| BURIAL | DEC 17, 1988 | CALVARY CEMETERY | HAZLETON | LUZERNE | PENNSYLVANIA |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. RECEIVED BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| FRANCIS J. COLLINS, JR. | 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901 | DEC 16 88 | Gina Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BA

DHMH 16 60M 7/84 (VRA 15, 4)

Item #1, Film G647, 1/3/89, cdl

0166922 DEC 20 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

88 REG. NO 37043

1. DECEASED NAME (TYPE OR PRINT) — FIRST: CONARD (Conrad) MIDDLE: Paul LAST: Edwards
2a. DATE OF DEATH — MONTH: 12 DAY: 7 YEAR: 88
2b. HOUR: 0203 A.M.
3. SEX: Male
4. RACE: black
5. DATE OF BIRTH — MONTH: 02 DAY: 06 YEAR: 23
6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.
7b. CITIZEN OF WHAT COUNTRY?: United States
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Takoma Park
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Asst. Principal
12b. KIND OF BUSINESS OR INDUSTRY: Public Schools

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: D.C.
13b. COUNTY:
13c. CITY OR TOWN: Washington
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE: 7313 Blair Road N.W., 20012

14. FATHER'S NAME — FIRST MIDDLE LAST: Conrad A. Edwards
15. MOTHER'S MAIDEN NAME — FIRST MIDDLE LAST: Marion Demby
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): WW II
16b. SOCIAL SECURITY NO.: 578-26-0300
17. INFORMANT — ADDRESS: Karen E. Washington, 7313 Blair Rd. N.W., Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure, COPD — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 YEARS
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: CHRONIC RENAL FAILURE

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET CITY OR TOWN COUNTY STATE

22a.1 certify that (I) (this hospital) attended the deceased from JUNE 19 88 to DEC. 6 19 88, that (I) (we) last saw the deceased alive on 12/6 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE: Joseph B. Mizgerd, M.D. — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒
22c. DATE SIGNED: 12/7/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOSEPH B. MIZGERD, M.D.
22e. ADDRESS: 7600 CARROLL AVE TAKOMA PARK, MD. 20854

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation
23b. DATE: 12/8/88
23c. NAME OF CEMETERY OR CREMATORY: J. Wm. Lee's Sons Co.
23d. LOCATION — CITY OR TOWN COUNTY STATE: Washington, D.C.
24. FUNERAL DIRECTOR — NAME ADDRESS: McGuire Funeral Service, 7400 Georgia Ave. N.W., Washington, DC
25a. DATE REC'D BY REGISTRAR: DEC 8 '88
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rondelle

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - HS 6008 7/84 (VRA 15.4)

017259 DEC 27 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37049
REG. NO

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Conrad | E | Epps | 12 19 88 | 305 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN. |
|---|---|---|---|---|---|
| Male | Black | 8 23 10 | 78 YRS | | |

| 7a. BIRTHPLACE (STATE OR COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Roseland, VA, USA | USA | MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | Montgomery Cty, MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Silver Spring | Medlantic Manor at Layhill | Truck driver | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| VA | USA | Roseland | YES ☒ NO ☐ | Unknown 99999 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Patrick | C | Epps | Lillie | | Allen |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Unknown | | 225-24-5141 | James Epps | 9613 Dalmatia Dr./Clinton, MD 20735 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Metastatic Pneumonia | 6 mos |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Carcinoma of Rectum | 6 mos |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| ☐ | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 10/25, 19 88, to 12/19, 19 88, that (I) (we) last saw the deceased alive on 12/18, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | 22c. DATE SIGNED |
|---|---|---|---|---|
| [signature] | MD | ATTENDING PHYSICIAN ☒ | MEDICAL DIRECTOR ☐ | STAFF PHYSICIAN ☐ | 12/19/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| K. J. BeNACK MD | 4115 Dolie DR. Wheaton, Md |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | 12/23/88 | Oak Hill Memorial Gardens | Massie Mill | | Va |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| S. B. Jenkins | 7474 Lee Highway Ext, Arlington, Va | DEC 21 1988 | Ina Davidson-Hendler |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

016010 DEC 13 88 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 37050

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove [illegible]. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. The medical examiner must be notified of once.

IMPORTANT: If Item 21 is marked, or Item 18 shows any injury, or other traumatic [illegible]

BP 20

DHMH - 16 50M 1/81 (VRA 15, 4)

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST | Raymond | L. | Evanosky | |
| 2a. DATE OF DEATH — MONTH DAY YEAR | December 1, 1988 | | | 2b. HOUR: 4:50 PM |
| 3. SEX | Male | | | |
| 4. RACE | Caucasian | | | |
| 5. DATE OF BIRTH — MONTH DAY YEAR | Nov. 19, 1932 | | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 56 YRS. | | | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Pennsylvania | | | |
| 7b. CITIZEN OF WHAT COUNTRY? | United States | | | |
| 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | | | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Montgomery County, MD. | | | |
| 10. CITY OR TOWN OF DEATH | Germantown | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12839 Kitchen House Way | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Technical Recruiter | | | 12b. KIND OF BUSINESS OR INDUSTRY: Computer |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Maryland | | | |
| 13b. COUNTY | Montgomery | | | |
| 13c. CITY OR TOWN | Germantown | | | |
| 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | | | | |
| 13e. STREET ADDRESS | 12839 Kitchen House Way/20874 | | | |
| 14. FATHER'S NAME — FIRST / MIDDLE / LAST | Frank | George | Evanouskas | |
| 15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST | Mildred | Agnes | Urgalavage | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | Yes | | | |
| 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | Korea | 173-26-8805 | | |
| 17. INFORMANT — ADDRESS | Susan C. Evanosky, same as #13 | | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Hepatoma

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from Sept, 19 88, to Dec 2, 19 88, that (I) (we) last saw the deceased alive on Nov 21, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED: Dec. 2, 1988 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): DAVID S. ETTINGER MD | 22e. ADDRESS: The Johns Hopkins Oncology Center Baltimore MD 21205 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION — CITY OR TOWN / COUNTY / STATE | |
| Burial | Dec. 5, 1988 | Gate of Heaven Cemetery | Silver Spring, Maryland | |
| 24. FUNERAL DIRECTOR — NAME / ADDRESS | Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Ave. Rockville, MD 20850 | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE | |
| | | DEC 5 '88 | Julia Davidson Randall | |

019029 JAN 13 89

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37051 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81 (VRA 15, 4)

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST |
|---|---|---|
| MERCEDES | NMI | FANJUL |

2a. DATE OF DEATH: MONTH 12 DAY 22 YEAR 88 — 2b. HOUR 9 05 P M

| 3. SEX | 4. RACE | 5. DATE OF BIRTH (MONTH DAY YEAR) | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR (MONTHS / DAYS) | IF UNDER 24 HRS. (HOURS / MIN.) |
|---|---|---|---|---|---|
| F | Caucasian | 5 30 12 | 76 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Cuba | USA | | MONTGOMERY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| SILVER SPRING | HOLY CROSS HOSPITAL | SUPERVISOR | C&P TELEPHONE |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MARYLAND | MONTGOMERY | GAITHERSBURG | YES ☐ NO ☐ | 884 DIAMOND DRIVE 20878 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| RODOLFO | | MARTINEZ | ADELA | | GOMEZ |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 217-76-4306 | MERCEDES FERNANDEZ/DAUGHTER/SAME AS 13 | |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiogenic Shock

DUE TO, OR AS A CONSEQUENCE OF (b) Acute Anterior Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this decedent) attended the deceased from 12/22 19 88, to 12/22 19 88, that (I) (was) last saw the deceased alive on 12/22 19 88, and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|---|
| Frank M. Gravino | MD | | 12/22/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Frank Gravino | 10313 ~~Holy Cross Hosp~~ Georgia Ave Silver Spring |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | DEC 24, 1988 | GATE OF HEAVEN CEM. | SILVER SPRING MONTGOMERY MD |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE RECEIVED BY REGISTRAR | 25b. REGISTRAR'S STAMP |
|---|---|---|
| FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901 | DEC 27 '88 | Julia Davidson-Nordella |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

88 REG. NO. 37052

019030 JAN 13

DECEASED NAME (TYPE OR PRINT): FIRST JANICE MIDDLE T. LAST FATTAL

2a. DATE OF DEATH: MONTH DECEMBER DAY 27 YEAR — 2b. HOUR 7:00 AM

3. SEX: FEMALE

4. RACE: CAUCASIAN

5. DATE OF BIRTH: MONTH NOVEMBER DAY 18 YEAR 1936

6. AGE (IN YEARS LAST BIRTHDAY): 52 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK

7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.

10. CITY OR TOWN OF DEATH: BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NIH, THE CLINICAL CENTER

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER

12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: MONTGOMERY

13c. CITY OR TOWN: GAITHERSBURG

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS / ZIP CODE: 11730 CLOPPER ROAD/ 20878

14. FATHER'S NAME: FIRST C. MIDDLE DAUCHY LAST THORNE

15. MOTHER'S MAIDEN NAME: FIRST VICTORIA MIDDLE BENJAMIN LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 122-28-3909

17. INFORMANT: S. GEORGE FATTAL — ADDRESS: SAME AS #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Meningeal Carcinomatosis
DUE TO, OR AS A CONSEQUENCE OF (b) Waldenstroms Macroglobulinemia
DUE TO, OR AS A CONSEQUENCE OF (c) LUNG CANCER
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from December 12, 19 88, to December 27, 19 88, that [X] (we) last saw the deceased alive on December 27, 19 88, and that in [X] (our) opinion death occurred on the date and hour and from the causes stated above, [X] (we) (did) [ ] (did not) view the body after death.

22b. SIGNATURE: John Barrett MD — DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]

22c. DATE SIGNED: 12/27/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): John Barrett

22e. ADDRESS: National Institutes of Health, 9000 Rockville pike, Bethesda, Maryland 20892

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: DECEMBER 30, 1988

23c. NAME OF CEMETERY OR CREMATORY: ST. MARY'S CEMETERY

23d. LOCATION: CITY OR TOWN ROCKVILLE / COUNTY MONTGOMERY / STATE MARYLAND

24. FUNERAL DIRECTOR: NAME ROBERT A. PUMPHREY FUNERAL HOME/ ROCKVILLE, INC. ADDRESS 300 WEST MONTGOMERY AVE., ROCKVILLE, MD 20850

25a. DATE REC'D. BY REGISTRAR: DEC 28 '88

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT. If Item 21 is marked or Item 18 says any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 12

DHMH - 16 60M 7/84
(VRA 15, 4)

017953 DEC -3 89 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37053 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Maude | MIDDLE: I. | LAST: Fetzer | 2a. DATE OF DEATH MONTH DAY YEAR: December 27, 1988 | 2b. HOUR: 9:20 PM | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Dec. 30, 1891 | 6. AGE (IN YEARS LAST BIRTHDAY): 96 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD. | | |
| 10. CITY OR TOWN OF DEATH: Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Montgomery | 13c. CITY OR TOWN: Olney | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 19320 Olney Mill Rd. 20832 | |
| 14. FATHER'S NAME FIRST: William | MIDDLE: Robert | LAST: Unglesbee | 15. MOTHER'S MAIDEN NAME FIRST: Mina | MIDDLE: | LAST: Burns |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 213-74-4776 | 17. INFORMANT ADDRESS: Dorothy F. Compton, Item 13 | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
DUE TO, OR AS A CONSEQUENCE OF
(b): Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Colon cancer

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: 12 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Bowel Blockage | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 11/30/88, 19__, to 12/27/88 19__, that (I) (we) last saw the deceased alive on 12/27/88 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Arthur F. Woodward Jr. — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED:

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Arthur F. Woodward, Jr., M.D.

22e. ADDRESS: 18111 Prince Phil Dr Olney

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Dec. 30, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: Damascus Meth. | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Damascus, Montgomery, Md. |
| 24. FUNERAL DIRECTOR NAME, ADDRESS: Olin L. Molesworth, P.A., Damascus, Md. | 25a. DATE REC'D. BY REGISTRAR: DEC 30 1988 | 25b. REGISTRAR'S SIGNATURE: | |

0181 59 JAN 5 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37054 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: SAMUEL | MIDDLE | LAST: FINE | 7a. DATE OF DEATH MONTH DAY YEAR: Dec 28 88 | 7b. HOUR: 3 42 P M | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR: JUNE 6 1923 | 6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN): PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH: SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): OFFICER | 12b. KIND OF BUSINESS OR INDUSTRY: FOREST SERVICE | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MARYLAND | MONTGOMERY | SILVER SPRING | YES [X] NO [ ] | 2710 WOODEDGE ROAD 20906 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | | |
|---|---|---|---|
| ABRAHAM / FINE | JANE / BRASLOW | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 198 12 8877 | 17. INFORMANT ADDRESS: ESTELLE FINE, 2710 WOODEDGE ROAD SILVER SPRING, MARYLAND |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROX. INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Congestive Heart failure | 2 yr |
| DUE TO, OR AS A CONSEQUENCE OF (b) | ARTERIOSCLEROTIC HEART DISEASE | 5 yrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Uremia, DIABETES MELLITUS

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 24 Dec 19 88, to 28 Dec 19 88, that (I) (we) last saw the deceased alive on 28 Dec 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | 22c. DATE SIGNED |
|---|---|---|---|---|
| Ira N Tublin | MD | ATTENDING PHYSICIAN [ ] | MEDICAL DIRECTOR [X] | STAFF PHYSICIAN [ ] | 28 Dec 88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| IRA N. TUBLIN | 8830 CAMERON ST S.S. MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 12/30/1988 | SHALOM MEMORIAL PARK | MORELAND PENNSYLVANIA |

| 24a. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C. | JAN 3 1989 | Julia Davidson-Randall |

DHMH - 1650M 1/81 (VRA 15, 4)

019163 JAN 1 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 7055

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH | DAY | YEAR | 2b. HOUR |
| Dov | Bernard | Fischman | 12 | 31 | 19 88 | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR | 2d. HOUR |
| Male | White | Sept. 1, 1970 | 18 YRS. | | | 12 31 19 88 | 3:28A M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Changhua, Taiwan | U.S.A. | | Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Bethesda | 4608 Verne Road | Student | ------- | | | | |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Bethesda | YES ☐ NO ☐ | 6908 Millwood Road (20817) |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Joel | | Fischman | Renee | | Goldin |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | -------- | 570-17-3424 | Joel Fischman;Father;6908 Millwood Road; | Bethesda, Md. 20817 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Multiple injuries | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21a. EXTERNAL CAUSE WAS | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 3:25 PM 12 31 19 88 | Pipe bomb explosion |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | garage | 4608 Verne Road | Bethesda | Mont. | MD |

22a. I certify that I took charge of the remains described above and on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural Causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Charles P. Kokes TITLE (SPECIFY) Acting Deputy Chief M.D. MEDICAL EXAMINER DATE SIGNED 1/1/89

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn St. Balto.MD.

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | 1/3/89 | B'Nai Israel Cong. Cemetery; Oxon Hill; | P.G.; | | Maryland |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| DANZANSKY-GOLDBERG MEMORIAL CHAPELS | 1170 Rockville Pike; Rockville, Md. 20852 | JAN 6 1989 | Jicha Davidson-Randall |

07/84 25M BP_____ DHMH - 17 (VR A15 ME (5))

017294 DEC 27 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

88 37056
REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| LOUIS | | FLAX | 12/18/88 | 2:50 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | CAUCASIAN | 12 11 22 | 66 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Washington DC | USA | XXX | MONTGOMERY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| SANDY SPRING | FRIENDS NURSING HOME | Attorney | LAW |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MD. | Montgomery | Rockville | YES ☒ NO ☐ | 5800 Nicholson Lane, #1007 (20852) |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| SAMUEL | M. | FLAX | SADIE | | GOLDBERG |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WWII | 579-20-6086 | Mary B. Flax; Wife; | 5800 Nicholson Lane, #1007 Rockville, Md. 20852 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiopulmonary arrest | 2 DA 12/18 |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Sepsis 2° osteomyelitis jaw | 7/22/88 |
| DUE TO, OR AS A CONSEQUENCE OF (c) | diabetes | 1980. |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
Presenile dementia.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| — | — | YES ☐ NO ☐ | YES ☐ — NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| | | — |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | — |

22a. I certify that (I) (this hospital) attended the deceased from 10/25/85 19 85 to 12/18 19 88, that (I (we) last saw the deceased alive on 12/18 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Andrew Schlesinger MD | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | 12/16/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Andrew Schlesinger MD | 18111 Prince Phillip Dr Olney MD 20832 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12/20/88 | Rock Creek Cemetery | Washington, D.C. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852 | DEC 21 1988 | Julia Davidson-Randall |

IMPORTANT: If Item 21 is marked on this line, this shows how injury, or other traumatic event, occurred, and must be reported at once to the medical examiner.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

016544 DEC 1988

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 37057 REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) | FIRST | MIDDLE | LAST |
|---|---|---|---|
| | FRANCIS | X. | FOLEY |

2a. DATE OF DEATH: MONTH 12 DAY 04 YEAR 88 — 2b. HOUR 445 PM

| 3. SEX | 4. RACE | 5. DATE OF BIRTH (MONTH DAY YEAR) | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR (MONTHS / DAYS) | IF UNDER 24 HRS (HOURS / MIN.) |
|---|---|---|---|---|---|
| MALE | CAUCASIAN | 07 17 03 | 85 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| WASHINGTON, DC | USA | | MONTGOMERY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| TAKOMA PARK | WASHINGTON ADVENTIST HOSPITAL | ACCOUNTANT | NAVY DEPT |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MARYLAND | MONTGOMERY | SILVER SPRING | YES ☐ NO ☒ | 410 TORRINGTON STREET 20901 |

| 14. FATHER'S NAME (FIRST / MIDDLE / LAST) | 15. MOTHER'S MAIDEN NAME (FIRST / MIDDLE / LAST) |
|---|---|
| DANIEL J. FOLEY | JOHANNA GRADY |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 577-60-6692 | NIECE JOAN O'ROURKE | 3705 QUEEN MARY DR OLNEY, MD 20832 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) Dysphagia secondary to stroke
DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary edema
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
2 Left Cerebral Vascular accidents

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| N/A | feeding Gastrostomy 11/88 | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | N/A |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from Nov. 30, 19 88, to Dec. 4, 19 88, that (I) (we) last saw the deceased alive on Dec. 4, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Susan Voss, MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/4/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| SUSAN Voss, MD | 10401 Old Georgetown Rd Bethesda, MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | DEC 7, 1988 | GATE OF HEAVEN CEM. | SILVER SPRING MONTGOMERY MD |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| FRANCIS J. COLLINS, JR. | 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901 | DEC 6 '88 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

018463 JAN -9 88 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37058 REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 8

DHMH - 1650M 1/81 (VRA 15, 4)

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: SARAH | MIDDLE: M. | LAST: FRAZIER | 2a. DATE OF DEATH MONTH DAY YEAR: 12-12-88 | 2b. HOUR: 2347 M |
| 3. SEX: Female | 4. RACE: Black | 5. DATE OF BIRTH MONTH DAY YEAR: 09 15 00 | 6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS. | IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH: Takoma Pk. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD | 13b. COUNTY: MOCO | 13c. CITY OR TOWN: Hyattsville | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET ADDRESS: 2014 Lewisdale Dr/20783 |
| 14. FATHER'S NAME FIRST: JOHN MIDDLE: TURNER LAST: | | 15. MOTHER'S MAIDEN NAME FIRST: Susie MIDDLE: Chase LAST: | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO: 214-36-3924 | 17. INFORMANT: Virginia Baker (Guardian) | ADDRESS: SAME AS #13 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF: (b) Congestive Cardiac Failure
DUE TO, OR AS A CONSEQUENCE OF: (c) Sepsis (d) Seizure Disorder
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Atherosclerotic Cardiovascular Disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Anaemia

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 11-18-, 19 88, to 12-12-, 19 88, that (I) (we) last saw the deceased alive on 12-12-, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: M.D. ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 12/13/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): G. M. DiMaio, M.D. 22e. ADDRESS: 6516 Kenilworth Ave Riverdale MD 20737

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12-20-88 | 23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Silver Spring, Montg, MD | |
| 24. FUNERAL DIRECTOR NAME: George R. Snowden | ADDRESS: Rockville, MD 20850 | 25a. DATE REC'D BY REGISTRAR: DEC 20 '88 | 25b. REGISTRAR'S SIGNATURE: Lucia Davidson-Randall | |

016229 DEC 15 88

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 88 37059

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Helen MIDDLE: H. LAST: Freedman | | | 2a. DATE OF DEATH MONTH DAY YEAR: 11/25/88 | 2b. HOUR: 1235 P M | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR: JANUARY 22, 1900 | 6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): CONNECTICUT | 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH: Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): EDITOR | 12b. KIND OF BUSINESS OR INDUSTRY: ASSISTANT TO PRESIDENT | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
|---|---|---|---|---|---|
| MARYLAND | MONTGOMERY | BETHESDA | YES XX NO ☐ | 5101 RIVER ROAD | 20816 |

| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | |
|---|---|---|---|---|---|
| FIRST: JOSEPH | MIDDLE: LOUIS | LAST: HOFFMAN | FIRST: REGINA | MIDDLE: | LAST: DREISNER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 579-48-0860A | SELIG FREEDMAN, 1706 NOYES LANE | SILVER SPRING, MARYLAND |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): respiratory failure — Approximate interval between onset and death: Immediate

DUE TO, OR AS A CONSEQUENCE OF (b): cerebrovascular accident — 2 days

DUE TO, OR AS A CONSEQUENCE OF (c): —

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): —

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| — | — | YES ☐ NO XX | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | — |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE — |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 11/23, 1988, to 11/25, 1988, that (I) (we) lost sight of the deceased alive on 11/24, 1988, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Ira Paul Kratting | MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 11-25-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Ira Paul Kratting MD | 2101 Medical Park Dr Silver Spring |

| 23a. BURIAL, CREMATION, REMOVAL | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| BURIAL | 11/28/1988 | ADAS ISRAEL CONGREGATION CEMETERY | WASHINGTON | | D. C. |

| 24. FUNERAL DIRECTOR (NAME AND ADDRESS) | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C. | NOV 29 1988 | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

017030 DEC 22 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37060
REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | Margaret / S. / Freeman | | | 2a DATE OF DEATH MONTH DAY YEAR | December 16, 1988 |
| | | | | 2b HOUR | 7:15 AM |
| 3. SEX | Female | 4. RACE | White | 5. DATE OF BIRTH MONTH DAY YEAR | Oct. 29 1899 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 89 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS. HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Virginia | 7b. CITIZEN OF WHAT COUNTRY? | USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH | Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Montgomery General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Homemaker |
| 12b. KIND OF BUSINESS OR INDUSTRY | own home | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Maryland | 13b. COUNTY | Montgomery | 13c. CITY OR TOWN | Sil. Spr. |
| 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | | 13e. STREET ADDRESS | 12120 Arbie Rd. 20904 | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | Richard / E. / Sanford | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Jeter / L. / Sisson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | N/A | (IF YES, GIVE WAR OR DATES) | N/A | 16b. SOCIAL SECURITY NO. | 578-28-4331 |
| 17. INFORMANT ADDRESS | William E. Dent-son- 812 Olive Dr. S.S. Md. | | | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CACHEXIA | TERM. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | CARCINOMATOSIS PELVIS | MONTHS |
| DUE TO, OR AS A CONSEQUENCE OF (c) | CARCINOMA ENDOCERVICOMA | MONTHS |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/1 19 88 to 12/16 19 88, that (I) (we) last saw the deceased alive on 12/16 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Donald R. Lewis DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED 12/16/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald R. Lewis, M.D. 22e. ADDRESS 1118 Pr. Phillip Dr. Olney, Md.

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Burial | 23b. DATE | 12-19-1988 |
| 23c. NAME OF CEMETERY OR CREMATORY | Parklawn Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE | Rockville Montgomery Md. |
| 24. FUNERAL DIRECTOR | Himes/Rinaldi Funeral Home | ADDRESS | 11800 N.H. Ave., Sil. Spr. Md. |
| 25a. DATE REC'D BY REGISTRAR | DEC 20 1988 | 25b. REGISTRAR'S SIGNATURE | Julia Davidson-Randall |

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

017743 DEC 30 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 037061

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 40

DHMH - 16 50M 1/81 (VRA 15, 4)

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Clairmont | D. | Friday | December 9, 1988 | 9:15 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Male | Caucasian | 7/ 06/ 03 | 85 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Ohio | United States | | Montgomery County, MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Olney | Montgomery General Hospital | Electrical Engineer | U.S. Gov't. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Silver Spring | YES ☐ NO XX | 15432 Bramblewood Drive/20906 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| August | | Friday | Mary | Catherine | Donnelly |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | | 384-09-4568 | Waive H. Friday, Wife, Same as #13 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) BILATERAL PNEUMONIA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION

DUE TO, OR AS A CONSEQUENCE OF (c) ALZHEIMER'S DEMENTIA

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO XX | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 12-6, 19 88, to 12-9, 19 88, that (I) (we) last saw the deceased alive on 12-9, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| TEHowe | MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | 12-9-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| TED E. HOWE | OLNEY, MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | Dec. 10, 1988 | Montgomery Crematorium, Inc. | Bethesda, Maryland |

| 24. FUNERAL NAME / ADDRESS | 25. DATE ACCEPTED BY REGISTRAR | 26. REGISTRAR'S SIGNATURE |
|---|---|---|
| Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814 | DEC 12 88 | Julia Davidson-Randall |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 37.062

0166911 DEC 20

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

| 1. DECEASED NAME (TYPE OR PRINT) | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
|---|---|---|---|---|---|---|---|---|
| | EILEEN | D. | FRIEDMAN | DECEMBER | 15 | | 1988 | 10:20A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| FEMALE | WHITE | NOVEMBER 19, YEAR 1945 | 43 YRS. | | | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| NEW YORK | U. S. A. | | MONTGOMERY COUNTY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| TAKOMA PARK | WASHINGTON ADVENTIST HOSPITAL | SECRETARY | ASSOCIATES |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MARYLAND | PRINCE GEORGE'S | BOWIE | YES ☒ NO ☐ | 15610 PLUMWOOD COURT 20716 |

| 14. FATHER'S NAME | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|---|---|
| | SAUL | | GRUBIN | | SALLYE | | WEINSTEIN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 085-36-0043 | LEONARD H. FRIEDMAN, | 15610 PLUMWOOD COURT BOWIE, MARYLAND |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) cerebral metastases

DUE TO, OR AS A CONSEQUENCE OF (b) metastatic breast cancer

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

pneumonia, bronchitis, emphysema

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☑ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED (WHILE AT WORK ☐ WHILE AT PLAY ☐) | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 8/25 19 87, to 12/15 19 88, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| | ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/15/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DR. LEWIS DENNIS, M. D. | 6201 GREENBELT ROAD, SUITE U 17 COLLEGE PARK, MARYLAND |

| 23a. BURIAL, CREMATION, REMOVAL | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| BURIAL | 12/16/1988 | MOUNT LEBANON CEMETERY | ADELPHI, | PRINCE GEORGE'S | MARYLAND |

| 24. NAME AND ADDRESS OF FACILITY | 25a. DATE RECD. BY REGISTRAR | 25b. REGISTRAR |
|---|---|---|
| DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C. | DEC 19 1988 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner shall be notified of such.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 037063

0174 12 DEC 28

1a. DECEASED NAME (TYPE OR PRINT) First: Rose Middle: H. Last: Friedman

2a. DATE OF DEATH Month: 12 Day: 23 Year: 88

2b. HOUR: 3:21 AM

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH Month: July Day: 21, Year: 1912

6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Saleswoman (Ret.)

12b. KIND OF BUSINESS OR INDUSTRY: Dept. Store

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Silver Srping

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 2416 Homestead Drive (20902)

14. FATHER'S NAME First: Max Middle: Last: Sugar

15. MOTHER'S MAIDEN NAME First: Mary Middle: Last: Baumohl

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

16b. (IF YES, GIVE WAR OR DATES): --------

16b. SOCIAL SECURITY NO.: 579-03-4451

17. INFORMANT ADDRESS: Drive; Silver Spring, Md.: Jacqueline Freidman; Daughter; 2416 Homestead

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIO PULMONARY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 20 MIN
DUE TO, OR AS A CONSEQUENCE OF (b): PULMONARY INSUFFICIENCY — 10 YRS
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: PULMONARY EMPHYSEMA, ALZHEIMERS DISEASE

19a. DATE OF OPERATION: 10/MAY

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: PULMONARY EMBOLISM

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/23, 19 88, to 12/23, 19 88, that (I) (~~saw~~) lost saw the deceased alive on ____, 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (did not) view the body after death.

22b. SIGNATURE: David Goldberg DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12/23/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DAVID GOLDBERG MD

22e. ADDRESS: 9801 GEORGIA AVE. SILVER SPRING MARYLAND 20901

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 12/26/88

23c. NAME OF CEMETERY OR CREMATORY: Temech Sedek Cemetery

23d. LOCATION CITY OR TOWN / COUNTY / STATE: Baltimore, Maryland

24. FUNERAL DIRECTOR NAME: DANZANSKY-GOLDBERG MEMORIAL CHAPELS
ADDRESS: 1170 Rockville Pike; Rockville, Md. 20852

25a. DATE REC'D BY REGISTRAR: DEC 27 1988

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Hardesty

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

018131 JAN -5 89

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 37064

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| REBECCA | B. | FUNGER | December 30, 1988 | 9:15a M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Female | Caucasian | Jan. 15, 1906 | 82 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Russia | U.S.A. | | Montgomery County, MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Rockville | 11420 Strand Drive, #212 | Homemaker | Home |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Rockville | YES ☒ NO ☐ | 11420 Strand Drive, #212 (20852) |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Abraham | | Brill | Gittel | | Sussel |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| NO | ---------- | 224-32-1276 | Morton Funger; Son; 9000 Dunham Drive; Potomac, Maryland 20854 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Liposarcoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24hrs

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). (Coroner Notified & Explained)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from NOV 28, 1986, to 12/30, 1988, that (I) (we) last saw the deceased alive on 11/1/88, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Lewis H Biben | MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/30/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| LEWIS H BIBEN | 1145-19TH ST NW WASHINGTON DC 20036 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 1/2/89 | King David Mem. Garden | Falls Church; Fairfax; Va. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852 | JAN 3 1989 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

30

BP

DHMH 16 50M 1/81 (VRA 15, 4)

018462 JAN -9 89

FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

88 37065
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST: HENRY | MIDDLE: B. | LAST: FUNKING | 2a. DATE OF DEATH MONTH DAY YEAR: Dec. 18 1988 | 2b. HOUR: 10 25 P M |
| 3. SEX: M | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR: 3 / 28 / 04 | 6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONT. | | MD. |
| 10. CITY OR TOWN OF DEATH: SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): BROKERAGE FIRM | 12b. KIND OF BUSINESS OR INDUSTRY: PARTNER | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MARYLAND | MONTGOMERY | SILVER SPRING | YES ☐ NO ☐ | 15301 PINE ORCHARD DRIVE 20906 |

| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |
|---|---|
| ERNEST FUNKING | MARY STAKE |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | 058-03-3535 | DAUGHTER MARGARET MORLEY | 4 CHARLESTON CT. CORAM, NY 11727 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Metastatic Carcinoma | 4 mos. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Carcinoma of Colon | 5+ mos. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Congestive Heart Failure, Arteriosclerotic Heart Disease

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I) (this hospital) attended the deceased from April 1986 to 12/18 1988, that (I) (we) last saw the deceased alive on 12/18 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| [signature] | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/19/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| R.T. BENACK MD | 4115 Colie Dr. Wheaton, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| BURIAL | DEC 22, 1988 | KENSICO CEMETERY | VALHALLA WESTCHESTER NY |

| 24. FUNERAL DIRECTOR NAME ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901 | DEC 20 '88 | Julia Davidson-Randall |

R BP

DHMH - 16 50M 1/81 (VRA 15, 4)

016534 DEC 19 8

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37066 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | Felice / Francis / Fusco | 2a. DATE OF DEATH MONTH DAY YEAR | December 5, 1988 | 2b. HOUR | 5:45 PM |
| 3. SEX | Male | 4. RACE | Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR | Jan. 18, 1913 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 75 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Washington, D.C. | 7b. CITIZEN OF WHAT COUNTRY? | United States | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Montgomery County, MD. | | | | |
| 10. CITY OR TOWN OF DEATH | Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 713 Wilson Avenue | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Vice President |
| 12b. KIND OF BUSINESS OR INDUSTRY | Co. Lithographic | | | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Rockville | YES [X] NO [ ] | 713 Wilson Avenue/20850 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Salvatore / Fusco | Lucia / Onorato |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | IF YES, GIVE WAR OR DATES | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| Yes | WW II | 229-34-7142 | Jacquelin N. Fusco, same as #13 |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) COLON CANCER — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 YEARS

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CARDIO-RESPIRATORY INSUFFICIENCY

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 10/10, 19 87, to 12/5, 19 88, that ~~I~~/(we) last saw the deceased alive on 11/29, 19 88, and that in ~~my~~/(our) opinion death occurred on the date and hour and from the causes stated above, ~~I~~/(we) ~~did~~/(did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN | 22c. DATE SIGNED |
|---|---|---|---|
| Daniel Rosenblum | MD | [ ] [X] [ ] | December 5, 1988 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Daniel Rosenblum M.D. | 10400 Connecticut Avenue Kensington, Maryland 20895 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec. 7, 1988 | Gate of Heaven Cem. | Silver Spring, Maryland |

| 24. FUNERAL DIRECTOR NAME | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 | DEC 5 '88 | Julia Davidson-Randall |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 37067

0165209 DEC 18 1988

1. DECEASED NAME (TYPE OR PRINT): LOUIS (FIRST) FUTTERMAN (LAST)

2a. DATE OF DEATH: DECEMBER 11, 1988 (MONTH DAY YEAR)

2b. HOUR: 11:30 AM

3. SEX: Male

4. RACE: Caucasian

5. DATE OF BIRTH: May 23, 1910 (MONTH DAY YEAR)

6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 11209 Markwood Dr.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Business Owner

12b. KIND OF BUSINESS OR INDUSTRY: Grocery

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Silver Spring

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 11209 Markwood Dr. (20902)

14. FATHER'S NAME: David Futterman (FIRST MIDDLE LAST)

15. MOTHER'S MAIDEN NAME: Bessie Glick (FIRST MIDDLE LAST)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): ----------

16b. SOCIAL SECURITY NO.: 103-01-9198

17. INFORMANT: Son ADDRESS: Cabin John, Md.
Steven Futterman: 8000 Cyprus Grove La.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary insufficiency
DUE TO, OR AS A CONSEQUENCE OF (b): Pulmonary emphysema
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 months / 2 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Carcinoma of left lung

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 12/12/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Jason Geiger, MD

22e. ADDRESS: 8830 Cameron St.: Silver Spring, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 12/13/88

23c. NAME OF CEMETERY OR CREMATORY: King David Mem. Gdn

23d. LOCATION: CITY OR TOWN Falls Church; COUNTY Fairfax; STATE Va.

24. FUNERAL DIRECTOR NAME: DANZANSKY-GOLDBERG MEMORIAL CHAPELS
ADDRESS: 1170 Rockville Pike; Rockville, Md. 20852

25a. DATE REC'D. BY REGISTRAR: DEC 15 1988

25b. REGISTRAR'S SIGNATURE: [signature] Davidson-Rondeau

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

016230 DEC 15 88 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37063 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | Clarence Leroy Gaasterland | 2a. DATE OF DEATH MONTH DAY YEAR | November 23, 1988 | 2b. HOUR | 8:55a M |
| 3. SEX | Male | 4. RACE | Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR | May 22, 1909 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 79 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Minnesota | 7b. CITIZEN OF WHAT COUNTRY? | United States | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH | Potomac | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Manor Care Nursing Home | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Commissioned Officer |
| 12b. KIND OF BUSINESS OR INDUSTRY | U.S. Navy | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Maryland | 13b. COUNTY | Montgomery | 13c. CITY OR TOWN | Kensington |
| 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | | 13e. STREET ADDRESS | 9624 Old Spring Road/20895 | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | John Gaasterland | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Geraldine J. Jansson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | Yes | (IF YES, GIVE WAR OR DATES) | WW 11 | 16b. SOCIAL SECURITY NO. | 473-44-7143 |
| 17. INFORMANT ADDRESS | Kathrine Wilkey Gaasterland 9624 Old Spring Road Kensington, Maryland 20895 | | | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Respiratory ARREST | 1 minute |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Carcinomatosis | 1 mo |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 11-21, 19 88, to 11-23, 19 88, that (I) (we) lost saw the deceased alive on 11-21, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Frederick G Barr | DEGREE MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ |
| 22c. DATE SIGNED | November 25, 1988 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | Frederick G. Barr M.D. | 22e. ADDRESS | 5454 Wisconsin Avenue Chevy Chase, Maryland 20815 |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Burial | 23b. DATE | November 30, 1988 | |
| 23c. NAME OF CEMETERY OR CREMATORY | Arlington National Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE | Arlington, Virginia | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 | 25a. DATE REC'D. BY REGISTRAR | NOV 29 1988 | 25b. REGISTRAR'S SIGNATURE |

DHMH - 1650M 1/81 (VRA 15, 4)

017744 DEC 30 88 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 37069 REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 27 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | Stella AKA Styliani / / Galanis | 2a. DATE OF DEATH MONTH DAY YEAR | December 7, 1988 | 2b. HOUR | 3:50 PM |
| 3. SEX | Female | 4. RACE | White | 5. DATE OF BIRTH MONTH DAY YEAR | October 24, 1905 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 83 YRS | IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Greece | 7b. CITIZEN OF WHAT COUNTRY? | Greece | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐ | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Montgomery County, MD. | | | | |
| 10. CITY OR TOWN OF DEATH | Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Shady Grove Adventist Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Homemaker |
| 12b. KIND OF BUSINESS OR INDUSTRY | Own home | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Maryland | 13b. COUNTY | Montgomery | 13c. CITY OR TOWN | Gaithersburg |
| 13d. INSIDE CITY LIMITS? YES ☐ NO XX | | 13e. STREET ADDRESS | 14058 Saddle River Drive | 20878 | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | Photios / / Skouras | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Elizabeth / / UNKNOWN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | No | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | 223-40-7836D |
| 17. INFORMANT ADDRESS | Mrs. Fay Makris, Daughter, same as #13 | | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Blast Crisis | 2 mo. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Chronic Myelogenous Leukemia | 5 years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO XX | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/7 19 83 to 12/7 19 88, that (I) (we) last saw the deceased alive on 12/7 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the couses stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Peter Sherer MD | DEGREE ATTENDING PHYSICIAN XX MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED Dec. 7, 1988 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | Peter B. Sherer, M.D. | 22e. ADDRESS | 3947 Ferrara Dr. Wheaton, md 20906 |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Burial | 23b. DATE | Dec. 10, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: Parklawn Memorial Park |
| 23d. LOCATION CITY OR TOWN / COUNTY / STATE | Rockville, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME | Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814 | 25a. DATE REC'D. BY REGISTRAR | DEC 9 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 37070

0159 82 DEC 1500

1. DECEASED NAME (TYPE OR PRINT): FIRST AUGUST MIDDLE PAUL LAST GALE
7a. DATE OF DEATH: MONTH DAY YEAR — DECEMBER 6, 1988
7b. HOUR: 2:15 P M
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: MONTH DAY YEAR — OCTOBER 16, 1930
6. AGE (IN YEARS LAST BIRTHDAY): 58 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS: HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Cambridge, Md.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY, MD.
10. CITY OR TOWN OF DEATH: BETHESDA
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NIH, THE CLINICAL CENTER
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Shop Coordinator - Preston
12b. KIND OF BUSINESS/INDUSTRY: Trucking

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY: Caroline
13c. CITY OR TOWN: FEDERALSBURG
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS / ZIP CODE: 302 WEST CENTRAL / 21632

14. FATHER'S NAME: FIRST Louis MIDDLE Gale LAST
15. MOTHER'S MAIDEN NAME: FIRST Helen MIDDLE Boevers LAST Gale
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 220-28-4898
17. INFORMANT ADDRESS: MRS. SHIRLEY W. GALE / SAME AS ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypotension
DUE TO, OR AS A CONSEQUENCE OF (b): Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (c): Lung Cancer, non small cell Cancer
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [X] NO [ ]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [X] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that [X] (this hospital) attended the deceased from AUGUST 8, 1988, to DECEMBER 6, 1988, that [X] (we) last saw the deceased alive on DECEMBER 6, 1988, and that in [X] (our) opinion death occurred on the date and hour and from the causes stated above, [X] (we) [did] [did not] view the body after death.
22b. SIGNATURE: Chrjohnson — DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]
22c. DATE SIGNED: 12-7-88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Chris Johnson
22e. ADDRESS: National Institutes of Health, 9000 Rockville pike, Bethesda, Maryland 20892

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Dec.9,1988
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
23d. LOCATION CITY OR TOWN: Federalsburg COUNTY: Caroline, STATE: Md.
24. FUNERAL DIRECTOR NAME AND ADDRESS: Framptom-Hawkins F.H., PO Box 43, Federalsburg, Md.
25a. DATE REC'D BY REGISTRAR: DEC 12 1988
25b. REGISTRAR'S SIGNATURE: Julia Sanders-Landers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

017759 DEC 30 1988

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37071 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Clifton | Clay | Garner | December 22, 1988 | 1:50am |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Male | White | July 12 1901 | 87 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Alabama | United States | | Montgomery County MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Silver Spring | 1131 University Blvd., West, #408 | Chief Inspector | U. S. Postal Service |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Montgomery | Silver Spring | YES ☒ NO ☐ | 1131 University Blvd., West, #408 20902 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Edgar | Earl | Garner | Ursula | | Ramsey |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WW II | 216-44-2869 | Ruby Garner, | Same as 13 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) MALNUTRITION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) PROSTATE CANCER

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from September 13, 19 88, to December 22, 19 88, that (I) (we) last saw the deceased alive on December 1, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Susan D Stein | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | Dec. 22, 1988 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Susan D. Stein, M. D. | 2101 Medical Park Drive, #304 Silver Spring, MD 20902 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12-23-88 | Parklawn Memorial Park | Rockville, Maryland |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Rapp Funeral Services, P. A. | 933 Gist Avenue, Silver Spring, MD 20910 | DEC 29 1988 | Kathleen Randall |

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

015768 DEC 12 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO 88 37072

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and forwarded with the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Cosimo | MIDDLE | LAST: Geppi | 2a. DATE OF DEATH MONTH: 12 DAY: 2 YEAR: 88 | 2b. HOUR: 0154A M | |
| 3. SEX: M | 4. RACE: Cau. | 5. DATE OF BIRTH MONTH: 3 DAY: 14 YEAR: 12 | 6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS | IF UNDER 1 YEAR MONTHS: DAYS: | IF UNDER 24 HRS HOURS: MIN.: |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery | MD. | |
| 10. CITY OR TOWN OF DEATH: Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SUBURBAN HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Truck Driver | 12b. KIND OF BUSINESS OR INDUSTRY: Trucking | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | Montgomery | Lexington Park | YES ☐ NO ☒ | RT. 2 Box 5 Charlotte Hall 20622 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Angelo | | Geppi | Francis | | LiBerto |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WW II | 216-12-2450 | Sylvia (Geppi) Cullen | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Dissecting Thoraco-Abdominal aorta
DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure - Resp. Failure
DUE TO, OR AS A CONSEQUENCE OF (c) Zagula Patty

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Status Post Ruptured A.A.A 2 Months ago

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| ☐ | | |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from Nov - 17, 19 88, to Dec - 1, 19 88, that (I) (we) last saw the deceased alive on 12 - 1, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| M. A. NAFISY, MD | 3925 - Ferrara Dr. S.S. MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | 12/5/88 | Meadowridge | Dorsey | | MD. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Frank Della Nace | 3224 Sisk Rd | DEC 8 1988 | Julia Davidson-Randolph |

BP_____

DHMH - 16 50M 1/81 (VRA 15: 4)

015794 DEC 12 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37073
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: HENRY | MIDDLE | LAST: GERBER | 2a. DATE OF DEATH MONTH: 12 DAY: 6 YEAR: 88 | 2b. HOUR: 4 17 PM | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH: 9 DAY: 01 YEAR: 24 | 6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): AUSTRIA | 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH: Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital | 12a. OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE): ENGINEER | 12b. KIND OF BUSINESS OR INDUSTRY: US GOVERNMENT | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND | 13b. COUNTY: PRINCE GEORGE'S | 13c. CITY OR TOWN: BELTSVILLE | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET ADDRESS: 11220 CHERRY HILL ROAD | 20705 |
| 14. FATHER'S NAME FIRST: RUDOLPH MIDDLE | LAST: GERBER | 15. MOTHER'S MAIDEN NAME FIRST: GISELA MIDDLE | LAST: LOBL | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES | (IF YES, GIVE WAR OR DATES): WWII | 16b. SOCIAL SECURITY NO.: 082 18 5096 | 17. INFORMANT ADDRESS: DIANA R. GERBER, 11220 CHERRY HILL ROAD BELTSVILLE, MARYLAND | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute encephalopathy — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b): End Stage Liver disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c): Chronic Active Hepatitis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cachexia

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: — | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: — | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ] | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: 4 17 PM 12 6 1988 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2): — | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/5/88, 19 88, to 12/6/88, 19 88, that (I) (we) last saw the deceased alive on 12/6, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: M-Wajeed Khan, MD — DEGREE — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 12/7/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): M-Wajeed Khan, MD — 22e. ADDRESS: 12102 Georgia Ave, Wheaton, MD

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL: BURIAL | 23b. DATE: 12/8/1988 | 23c. NAME OF CEMETERY OR CREMATORY: JUDEAN MEMORIAL GARDENS | 23d. LOCATION CITY OR TOWN: OLNEY COUNTY: MONTGOMERY STATE: MARYLAND | |
| 24. FUNERAL DIRECTOR NAME: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME ADDRESS: 232 CARROLL STREET, N. W., WASHINGTON, D.C. | | | 25a. DATE REC'D BY REGISTRAR: DEC 09 1988 | 25b. REGISTRAR'S SIGNATURE: Julie Davidson-Rudasa |

BP_____

DHMH - 16 50M 1/81
(VRA 15, 4)

17575 DEC 30 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 37074

1. DECEASED NAME (TYPE OR PRINT): FIRST NICK MIDDLE C. LAST GIAQUINTA
2a. DATE OF DEATH: MONTH 12 DAY 10 YEAR 88
2b. HOUR: 10:00 A M
3. SEX: MALE
4. RACE: CAUCASIAN
5. DATE OF BIRTH: MONTH NOV DAY 8 YEAR 1904
6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): ITALY
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: SILVER SPRING
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CEMENT MASON
12b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY: MONTGOMERY
13c. CITY OR TOWN: SILVER SPRING
13d. INSIDE CITY LIMITS? YES [ ] NO [ ]
13e. STREET ADDRESS: 404 DALE DRIVE 20910

14. FATHER'S NAME: FIRST JOSEPH MIDDLE LAST GIAQUINTA
15. MOTHER'S MAIDEN NAME: FIRST JOSEPHINE MIDDLE LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 579-01-4788
17. INFORMANT ADDRESS: JOSEPHINE GIAQUINTA/WIFE/SAME AS 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 Hrs.
DUE TO, OR AS A CONSEQUENCE OF (b): Pulmonary Edema.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c): Ischemic Cardiomyopathy

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Renal Failure

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/6/88, 19__, to 12/10/88, 19__, that (I) (we) last saw the deceased alive on 12/10, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE, DEGREE: [signature] MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 12/10/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): DONALD BISKIND
22e. ADDRESS: 10313 Georgia Ave Silver Spring MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: DEC 13, 1988
23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEM.
23d. LOCATION: CITY OR TOWN SILVER SPRING COUNTY MONTGOMERY STATE MD

24. FUNERAL DIRECTOR: NAME FRANCIS J. COLLINS, JR.
ADDRESS 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901
25a. DATE REC'D BY REGISTRAR: DEC 12 '88
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

017155 DEC 27 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 88 37075

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: NORMAN MIDDLE: | LAST: GINN | 2a. DATE OF DEATH MONTH DAY YEAR: 12-21-88 | 2b. HOUR: 9:39 P M | | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: 09-22-26 | 6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. | 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH: Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Hebrew Home of Greater Washington | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerk | 12b. KIND OF BUSINESS OR INDUSTRY: Trade Mark U.S. Patent & | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Damascus | YES ☐ NO ☐ | 28616 Kemptown Road (20872) |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Hirsch / / Ginn | Sophie / / Corr |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WWII | 264-46-1174 | Harold Ginn;Son; | 28616 Kemptown Rd.; Damascus, Md. 20872 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary Arrest. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): acute Cerebrovascular accident — sudden

DUE TO, OR AS A CONSEQUENCE OF (c): Severe Atherosclerosis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 11-29 19 88 to 12-21 19 88 that (I) (we) last saw the deceased alive on 12-21 19 88 and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | 22c. DATE SIGNED |
|---|---|---|---|---|
| Loreto S. Albiol | MD | ATTENDING PHYSICIAN ☑ | MEDICAL DIRECTOR ☐ | STAFF PHYSICIAN ☐ | 12-21-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| LORETO S. ALBIOL, MD | 8121 MONTROSE Rd. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12/23/88 | King David Mem. Garden | Falls Church; Fairfax; Va. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852 | DEC 23 1988 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10 1R BP

DHMH - 1650M 1/81 (VRA 15, 4)

1600.5 DEC 13 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO. 37076

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove Pages 2 and 3 and return Page 1 with the medical examiner's report, if one is required, to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal from the state.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other than natural cause of death, a medical examiner's report must be filed.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Evelyn | MIDDLE: Frances | LAST: Gohlke | 2a. DATE OF DEATH MONTH DAY YEAR: December 2, 1988 | 2b. HOUR: 1:30 P M | |
| 3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: 04 21 98 | 6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): TEXAS | 7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH: Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 714 Harrington Road | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Cashier | 12b. KIND OF BUSINESS OR INDUSTRY: Retail | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Montgomery | 13c. CITY OR TOWN: Rockville | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 714 Harrington Road/20852 | |
| 14. FATHER'S NAME FIRST: John | MIDDLE | LAST: Abbott | 15. MOTHER'S MAIDEN NAME FIRST: Emily | MIDDLE: Frances | LAST: Thornton |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 467-09-8409A | 17. INFORMANT ADDRESS: Jack W. O'Dell, same as #13 | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Myocardial infarction | 1d |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Arteriosclerotic heart disease | 10 yrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 4 Nov 88 to 2 Dec 88, that (I) (we) lost sight of the deceased alive on 2 Dec 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Paul T. Noone | DEGREE: MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 2 Dec 88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Paul T. Noone, M.D. | 22e. ADDRESS: 50 West Edmonston Drive Rockville, Maryland 20852 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation | 23b. DATE: Dec. 3, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: Montgomery Crematorium Inc. | 23d. LOCATION CITY OR TOWN: Bethesda | COUNTY / STATE: Maryland |
| 24. FUNERAL DIRECTOR NAME: Robert A. Pumphrey Funeral Home, Rockville, Inc. ADDRESS: 300 West Montgomery Ave. Rockville, MD 20850 | | 25. DATE RECEIVED BY REGISTRAR: DEC 5 88 | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 37077

0160008 DEC 12

1. DECEASED NAME (TYPE OR PRINT): Anna (First) Petro (Middle) Golian (Last)

2a. DATE OF DEATH: 12 02 88 (Month Day Year) 2b. HOUR: 5:23 pm

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH: June 9, 1917 (Month Day Year)

6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS. IF UNDER 1 YEAR: MONTHS DAYS. IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Waitress

12b. KIND OF BUSINESS OR INDUSTRY: Restaurant

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Rockville

13d. INSIDE CITY LIMITS? YES ☐ NO XX

13e. STREET ADDRESS: 11406 Schuylkill Road/20852

14. FATHER'S NAME: Wasco (First) (Middle) Petro (Last)

15. MOTHER'S MAIDEN NAME: Elsie (First) (Middle) Ditchko (Last)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 109-18-2424

17. INFORMANT: Andrew J. Golian, same as #13 (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Myocardial infarction | 1 hour |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Arteriosclerotic Heart Disease | 10 yrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from [illegible] 19 65, to 2 Dec 19 88, that (I) (we) last saw the deceased alive on 02 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Paul T Noone DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/24/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Paul T. Noone, M.D.

22e. ADDRESS: 50 West Edmonston Drive, Rockville, Maryland 20852

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Dec. 5 1988

23c. NAME OF CEMETERY OR CREMATORY: Parklawn Memorial Park

23d. LOCATION: CITY OR TOWN, COUNTY, STATE: Rockville, Maryland

24. FUNERAL DIRECTOR NAME AND ADDRESS: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Ave. Rockville, MD 20850

25. DATE REC'D BY REGISTRAR: DEC 5 88

26. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall

IMPORTANT: If item 21 is marked "yes," the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1650M 1/81 (VRA 15, 4)

017752 DEC 30 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3707 8

1. DECEASED NAME (TYPE OR PRINT) — FIRST: ZVI — MIDDLE: — LAST: GOLOMB

2a. DATE OF DEATH — KNOWN ☑ / ESTIMATED ☐ — MONTH: 12 — DAY: 26 — YEAR: 19 88 — 2b. HOUR: 12 15 PM

3. SEX: MALE — 4. RACE: WHITE — 5. DATE OF BIRTH: MONTH 5 DAY 29 YEAR 05 — 6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD — MONTH 12 DAY 26 YEAR 19 88 — 2d. HOUR 12 15 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): POLAND — 7b. CITIZEN OF WHAT COUNTRY?: ISRAEL — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD

10. CITY OR TOWN OF DEATH: Silver Spring — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): PLUMBER — 12b. KIND OF BUSINESS OR INDUSTRY: PLUMBING

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD — 13b. COUNTY: Montgomery — 13c. CITY OR TOWN: Wheaton — 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ — 13e. STREET ADDRESS: 11403 Monticello Ave 20902

14. FATHER'S NAME: MORDECHAI — MIDDLE: — LAST: GOLOMB

15. MOTHER'S MAIDEN NAME: MIRIAM — MIDDLE: — LAST: LAUTENBERG

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: none

17. INFORMANT: ELI AVIDAN — ADDRESS: 11403 MONTICELLO AVENUE, SILVER SPRING, MARYLAND

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiorespiratory failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Metastatic Carcinoma of Lung — 1 year

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Metastic Carcinoma, Lung, to Bone and Brain

19a. DATE OF OPERATION: N/A — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): N/A

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Paul A. DeVore M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 12/26/88

EXAMINER'S NAME (TYPE OR PRINT): PAUL A DEVORE MD — ADDRESS: 4203 Queensbury Rd HYATTSVILLE MD 20781

23a. BURIAL, CREMATION, REMOVAL: REMOVAL — 23b. DATE: 12/27/1988 — 23c. NAME OF CEMETERY OR CREMATORY: MAALIN BAKODESH SOCIETY — 23d. LOCATION CITY OR TOWN: BROOKLYN — COUNTY — STATE: NEW YORK

24. FUNERAL DIRECTOR AND ADDRESS: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.

25a. DATE REC'D. BY REGISTRAR: DEC 29 1988 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

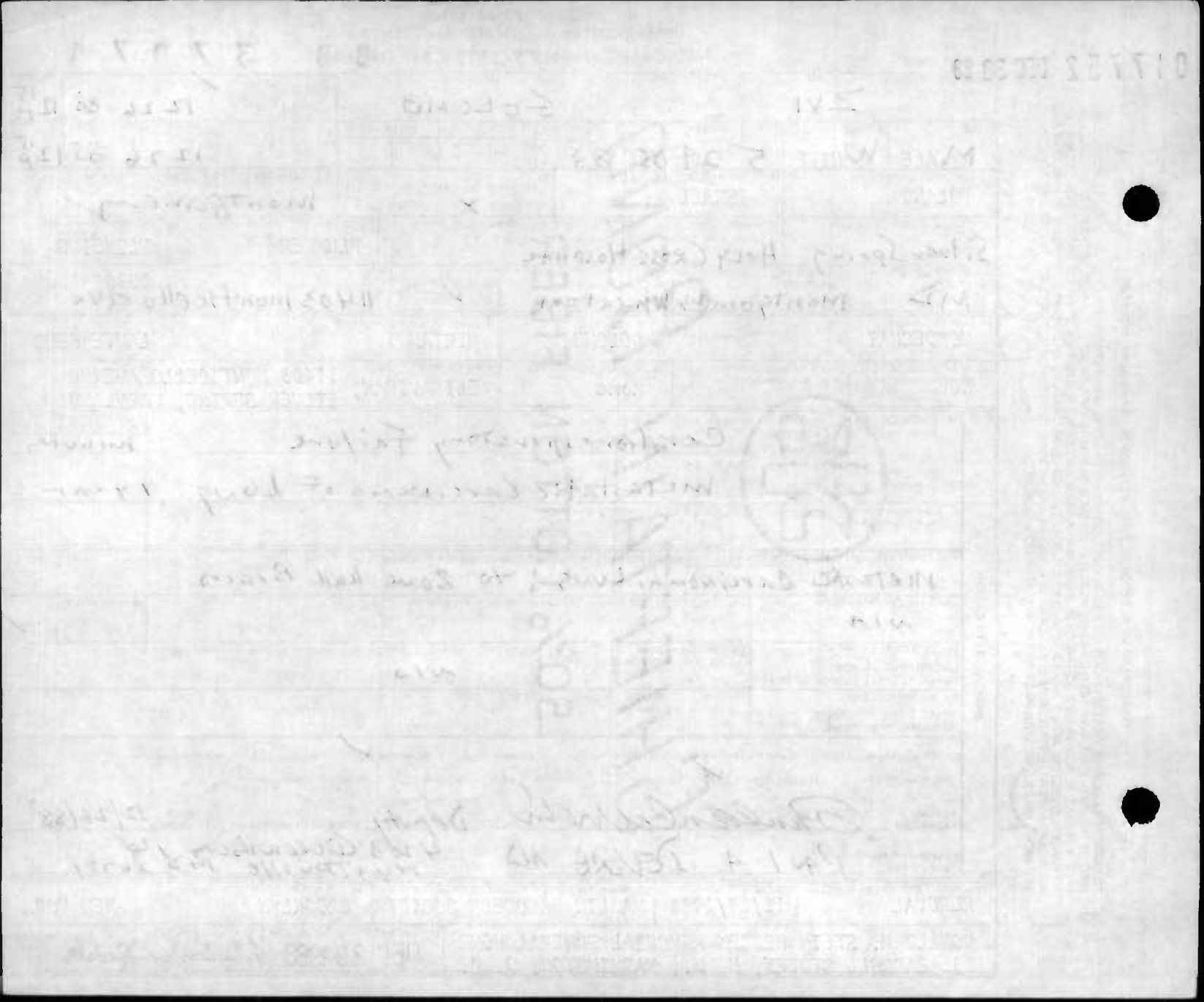
**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

5

07/84 25M BP

DHMH - 17 (VR A15 ME (5))



016768 DEC 2088

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 7 0 7 9

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ MONTH | DAY | YEAR | 2b. HOUR |
| Sigmund | | Goodman | 12 | 10 | 1988 | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS) LAST BIRTHDAY | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR | 2d. HOUR |
| M | C | 10 05 34 | 54 YRS. | | | 12 10 1988 | 858 PM |

| | | | | |
|---|---|---|---|---|
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARITAL STATUS | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| ONTARIO | U.S.A. | MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | MONTGOMERY | MD. |

| | | | |
|---|---|---|---|
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| BETHESDA | Suburban Hospital | Broker | Real Estate |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| MD | MONTGOMERY | CHEVY CHASE | YES ☑ NO ☐ | 7113 RIDGEWOOD AVE (20815) |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | |
| Maxwell | Goodman | Ruth | Rosen |

| | | | |
|---|---|---|---|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Wife) ADDRESS |
| No | ---------- | 209-34-0923 | Pattie Goodman: 7113 Ridgewood Ave. Chevy Chase, Md |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ACUTE

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — INDEF

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☑ |
| | | |

| | | | |
|---|---|---|---|
| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| | 0815 PM 12 10 1988 | COLLAPSED AT HOME | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |
| | HOME | 7113 RIDGEWOOD AVE CHEVY CHASE MONT MD | |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Dept MEDICAL EXAMINER DATE SIGNED 12/20/88

EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C MAYLE ADDRESS 7200 WISCONSIN AVE BETHESDA MD 20814

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE | |
| Burial | 12/13/88 | Pardes Shalom Cemetery | Maple, Ontario | |

| | | |
|---|---|---|
| 24. FUNERAL DIRECTOR NAME | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| Danzansky-Goldberg Memorial Chapels 1170 Rockville Pike. Rockville, Md | DEC 19 1988 | [signature] |

DHMH - 17 (VR A15 ME (5))

19037 JAN 13 89 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37080 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| John | | Gonella | December 23, 1988 | 8:30 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Male | White | Jan. 5, 1917 | 71 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Scotland | USA | | Montgomery MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Chevy Chase | 3543 Hamlet Place | Lobbyist | Railroad |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 20815

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Chevy Chase | YES ☒ NO ☐ | 3543 Hamlet Place |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| John Gonella | | | Margaret | Christie | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 263-42-7182 | Ashton G. Gonella Chevy Chase, MD | 3543 Hamlet Place |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | cardiorespiratory arrest | 1 min |
| DUE TO, OR AS A CONSEQUENCE OF (b) | caused by esophagus | 22 months |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| ☐ | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 2/17, 19 87, to 2/23, 19 88, that (I) (we) last saw the deceased alive on 2/21, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
|---|---|---|---|
| Bruce A. Silver | MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Bruce A. Silver M.D. | 106 Irving St.N.W.Suite 421, Washington, D.C. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | 12-27-88 | Mt. Comfort Crematory | Axandria, MD |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Joseph Gawler's Sons, Washington, DC | DEC 28 '88 | Julia Davidson-Randall |

R

BP 15

DHMH - 16 50M 1/81 (VRA 15, 4)

019161 JAN 13 89 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37081 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: RUTH | MIDDLE | LAST: GORELICK | 2a. DATE OF DEATH MONTH DAY YEAR: December 30, 1988 | 2b. HOUR: 9:00 PM | |
| 3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: December 25, 1907 | 6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York City | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH: Potomac | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 8712 Post Oak Rd. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Home | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Silver Spring | YES ☐ NO ☒ | 14508 Homecrest Rd (20906) |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Judah / / Ostrover | Toby / / Ostrover |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | ------- | 111-05-2708 | Joyce Cohen: 8712 Post Oak Rd.: Potomac, Md |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiorespiratory Arrest. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b) Scleroderma — 10 yrs

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from October, 19 88, to Dec 28, 19 88, that (I) (we) last saw the deceased alive on December 20, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN | 22c. DATE SIGNED |
|---|---|---|---|
| T. MARCINI | M.D. | ☐ ☒ ☐ | 12/31/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Thomas Marcini | 9711 Medical Center Dr. Rockville, MD 20850 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 1/2/89 | King David Mem. Gdn. | Falls Church / Va. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike: Rockville, Md 20852 | JAN 6 1989 | |

IMPORTANT: If item 21 is marked or item 18 should say injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

018161 JAN -5 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81
(VRA 15, 4)

1 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

88 37082
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST MORRIS MIDDLE LAST GOTTLIEB

2a. DATE OF DEATH: MONTH 12 DAY 29 YEAR 88

2b. HOUR 9:57 M

3. SEX: MALE

4. RACE: WHITE

5. DATE OF BIRTH: MONTH 3 DAY 4 YEAR 09

6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS

# UNDER 1 YEAR: MONTHS / DAYS

# UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW JERSEY

7b. CITIZEN OF WHAT COUNTRY?: U. S. A.

8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.

10. CITY OR TOWN OF DEATH: ROCKVILLE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HEBREW HOME OF GREATER WASHINGTON

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): PODIATRIST

12b. KIND OF BUSINESS OR INDUSTRY: MEDICINE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYALND

13b. COUNTY: MONTGOMERY

13c. CITY OR TOWN: SILVER SPRING

13d. INSIDE CITY LIMITS? YES XX NO ☐

13e. STREET ADDRESS: 903 HOLBORN STREET 20902

14. FATHER'S NAME: FIRST JOSEPH MIDDLE LAST GOTTLIEB

15. MOTHER'S MAIDEN NAME: FIRST GUSSIE MIDDLE LAST FARBER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 579-52-1871

17. INFORMANT: SONIA GOTTLIEB, SILVER SPRING, MARYLAND

ADDRESS: 909 HOLBORN STREET

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): UROSEPSIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): ARTHEROSCLEROTIC CEREBROVASCULAR DISEASE — 7 YEARS

DUE TO, OR AS A CONSEQUENCE OF (c): DIABETES MELLITUS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO XX

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/2 19 86 to 12/29 19 88, that (I) (we) last saw the deceased alive on 12/29 19 88, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Steven Lipson — DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR XX STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12/29/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): STEVEN LIPSON

22e. ADDRESS: 6121 MONTROSE RD, ROCKVILLE

23a. BURIAL, CREMATION, REMOVAL: BURIAL

23b. DATE: 12/30/1988

23c. NAME OF CEMETERY OR CREMATORY: OHEV SHOLOM TALMUD TORAH CONGREGATION CEMETERY

23d. LOCATION: CITY OR TOWN WASHINGTON COUNTY D. C. STATE

24. FUNERAL DIRECTOR (NAME AND ADDRESS): DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME, 232 CARROLL STREET, N. W., WASHINGTON, D. C.

25a. DATE REC'D. BY REGISTRAR: MAY 3 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rondeau

015996 DEC 13 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37083 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other unnatural event, the medical examiner must be notified at once.

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Linaria | MIDDLE: Bernice | LAST: Goudie | 2a. DATE OF DEATH MONTH DAY YEAR: December 2, 1988 | 2b. HOUR: 9:08 pm | |
| 3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: 6/2/04 | 6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Iowa | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery | MD. | |
| 10. CITY OR TOWN OF DEATH: Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Home Maker | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Calvert | 13c. CITY OR TOWN: Owings | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 9121 Hall Court | 20736 |
| 14. FATHER'S NAME FIRST: Willart | MIDDLE: T. | LAST: Hull | 15. MOTHER'S MAIDEN NAME FIRST: Nancy | MIDDLE: E. | LAST: Lowder |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 534-16-1128 | 17. INFORMANT: John Goudie | ADDRESS: 9121 Hall Court Owings, Md 20736 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Respiratory Arrest | 5 min. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Acute pneumonia | 5 D. y. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Chronic obstructive pulmonary Disease | 20 YR. |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from Nov. 30, 19 88 to Dec. 2 19 88, that (I) (we) last saw the deceased alive on Dec. 2, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | 22c. DATE SIGNED |
|---|---|---|---|---|
| Frank J. Mayo | MD | ATTENDING PHYSICIAN ☐ | MEDICAL DIRECTOR ☐ | STAFF PHYSICIAN ☑ | 12-3-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| FRANK J. MAYO, MD | 16220 Frederick Rd. #213 Gaithersburg, MD 20877 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | 12/04/88 | Metropolitan Crem. | Alexandria / Virginia |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Avenue, Hyattsville, MD 20781 | DEC 5 '88 | Julia Davidson-Randall |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 88 037084

018461 JAN - 0

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED BY ME.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

| | | | | | |
|---|---|---|---|---|---|
| DECEASED NAME (TYPE OR PRINT) First: HORACE Middle: Chilton Last: GRAHAM SR. | | | | 2a. DATE OF DEATH Month: 12 Day: Year: 1988 | 2b. HOUR 735 A M |
| 3. SEX: Male | 4. RACE: Caucasian | 5. DATE OF BIRTH Month: Sept. Day: 1 Year: 1919 | 6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS | If UNDER 1 YEAR Months / Days | If UNDER 24 HRS. Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Texas | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD. | | |
| 10. CITY OR TOWN OF DEATH: Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Engineer | 12b. KIND OF BUSINESS OR INDUSTRY: Navy | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Bethesda | YES [ ] NO [X] | 10636 Montrose Avenue #204 20814 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last |
|---|---|
| Horace / Chilton / Graham, Sr. | Olive / / Burke |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| Yes | WW II | 455-09-8528 | Lorinda M. Graham, Same as #13 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: several hrs
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from Oct 13, 19 87, to 19 Dec 19 88, that (I) (we) last saw the deceased alive on 16 Dec 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE DEGREE | ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED |
|---|---|---|
| [signature] | | 19 Dec 88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| SERE J. DAUM | 7505 Democracy Blvd Bethesda MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec. 22 1988 | Laurel Land Cemetery | Ft. Worth, Texas |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814 | DEC 20 '88 | Julia Davidson-Randall |

R BP 10+1

DHMH - 16 50M 1/81 (VRA 15, 4)

015926 DEC 13 881 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

REG. NO. 88 37085

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Philip MIDDLE: B. LAST: Gravitz | | | 2a. DATE OF DEATH MONTH: Dec DAY: 6 YEAR: 88 | 2b. HOUR: 11:10 AM | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH: 10 DAY: 17 YEAR: 03 | 6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS | IF UNDER 1 YEAR MONTHS: DAYS: | IF UNDER 24 HRS HOURS: MIN: |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Lithuania | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH: Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Hebrew Home of Greater Wash. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Self-Employed | 12b. KIND OF BUSINESS OR INDUSTRY: Barber | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD. | 13b. COUNTY: Montgomery | 13c. CITY OR TOWN: Silver Spring | 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ | 13e. STREET ADDRESS (ZIP 20902): 1121 University Blvd. W #501 | |
| 14. FATHER'S NAME FIRST: Chaim MIDDLE: LAST: Gravitz | | | 15. MOTHER'S MAIDEN NAME FIRST: Sylvia MIDDLE: LAST: Gal | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES): ----- | 16b. SOCIAL SECURITY NO.: 578-42-4500 | 17. INFORMANT (Son) ADDRESS: Melvin Gravitz: 11420 Strand Dr. #102 Rockville, Md | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Malignant melanoma of rectum with metast.
DUE TO, OR AS A CONSEQUENCE OF (c): to liver., Hypertension,

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): —

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from March 21 19 88 to Dec. 8 19 88, that (I) (we) last saw the deceased alive on Dec 8 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Michael Felder D.O. DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑ — 22c. DATE SIGNED: 12/8/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MICHAEL FELDER, DO — 22e. ADDRESS: Hebrew Home for Aged. Rockville, MD.

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/9/88 | 23c. NAME OF CEMETERY OR CREMATORY: King David Mem. Gdn | 23d. LOCATION CITY OR TOWN: Falls Church | COUNTY / STATE: Va. |
| 24. FUNERAL DIRECTOR NAME AND ADDRESS: DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pk: Rockville, Md 20852 | | 25a. DATE REC'D. BY REGISTRAR: DEC 12 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landers | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG NO. 37086

0165 19 DEC 16 58

1a. DECEASED NAME (TYPE OR PRINT) — FIRST: Dav.D — MIDDLE: MARK — LAST: Greenbaum

2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☑ — MONTH 12 DAY 10 YEAR 19 88 — 2b. HOUR 3:45 P.M.

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: MONTH 8 DAY 22 YEAR 50 — 6. AGE (IN YEARS LAST BIRTHDAY): 38 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD — MONTH 12 DAY 11 YEAR 19 88 — 2d. HOUR 11 03 A.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 575 Thayer Avenue, #607

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Health & HumanSvc's.

12b. KIND OF BUSINESS OR INDUSTRY: U.S.Gov't.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Montgomery — 13c. CITY OR TOWN: Silver Spring — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 575 Thayer Avenue,#607 20910

14. FATHER'S NAME — FIRST: Seymour — MIDDLE — LAST: Greenbaum

15. MOTHER'S MAIDEN NAME — FIRST: Veleta — MIDDLE — LAST: Sternberg

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES): ----------

16b. SOCIAL SECURITY NO.: 218-54-5760

17. INFORMANT — ADDRESS: Boston, MA 02130 Sigourney Street;Brother;16 Cranston St.,

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CardioRespiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate couse (a) stoting the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b): Seizure Disorder

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Naturol couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐,

ACTUAL SIGNATURE: John Lauber M.D. TITLE (SPECIFY): MEDICAL EXAMINER DATE SIGNED: 12-11-88

EXAMINER'S NAME (TYPE OR PRINT): John Lauber ADDRESS: 8218 Wisconsin Ave

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation — 23b. DATE: 12/13/88 — 23c. NAME OF CEMETERY OR CREMATORY: Lee Crematory — 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Washington, D.C.

24. FUNERAL DIRECTOR NAME: DANZANSKY-GOLDBERG MEMORIAL CHAPELS — ADDRESS: 1170 Rockville Pike; Rockville, Md. 20852

25a. DATE REC'D. BY REGISTRAR: DEC 15 1988 — 25b. REGISTRAR'S SIGNATURE: Davidson-Randall

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

017944 DEC-3 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 037087

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: DoRothea; Middle: ; Last: GreenberG | | | 2a. DATE OF DEATH Month: 12; Day: 28; Year: 88 | 2b. HOUR 9:15 A.M. | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH Month: 8; Day: 12; Year: 12 | 6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS. | IF UNDER 1 YEAR Months: ; Days: | IF UNDER 24 HRS. Hours: ; Min: |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Hamilton, Ohio | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH: BethesdA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Surburban Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): N/A | 12b. KIND OF BUSINESS OR INDUSTRY: N/A | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Ohio | 13b. COUNTY: Hamilton | 13c. CITY OR TOWN: Amerley Village | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 7211 W. Aracoma Drive | |
| 14. FATHER'S NAME First: James; Middle: ; Last: Stevenson | | 15. MOTHER'S MAIDEN NAME First: Edna; Middle: ; Last: Smith | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES): --------- | 16b. SOCIAL SECURITY NO.: 270-01-9747 | 17. INFORMANT: Gail Schaumberg; Daughter; | ADDRESS: Rockville, Md. 20852 10804 Mazwood Place | |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Brain metastasis — Approximate interval between onset and death: 2 mo

DUE TO, OR AS A CONSEQUENCE OF (b): Colon cancer — 4 yr

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Lung + Bone meta

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: NA | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: NA | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐, NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that I (this hospital) attended the deceased from 12/24 19 88 to 12/28 19 88 that I (we) last saw the deceased alive on 12/27 19 88 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: Peter Sherer | DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12/28/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Peter Sherer MD | 22e. ADDRESS: 3947 Ferrara Dr. Wheaton md 20906 | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/30/88 | 23c. NAME OF CEMETERY OR CREMATORY: United Jewish Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Montgomery; Hamilton; Ohio | |
| 24. FUNERAL DIRECTOR NAME: DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS: 1170 Rockville Pike; Rockville, Md. 20852 | | 25a. DATE REC'D BY REGISTRAR: DEC 30 1988 | 25b. REGISTRAR'S SIGNATURE | |

017756 DEC 30 88

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

88 REG. NO. 37088

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Lawrence | MIDDLE | LAST: GROSE | 2a. DATE OF DEATH MONTH DAY YEAR: 12 27 88 | 2b. HOUR: 320 PM |
| 3. SEX: Male | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: Dec. 8, 1918 | 6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD | |
| 10. CITY OR TOWN OF DEATH: CHEVY CHASE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 4004 Woodlawn Rd. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Economist | 12b. KIND OF BUSINESS OR INDUSTRY: Government | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | CC | YES [X] NO [ ] | 4004 Woodlawn Rd. 20815 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Phillip | | Grose | Ethel | | Kobelmeister |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WW II | 061 09 3093 | Wife: Rosalyn Grose | same as #13 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Lung Carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 18 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (the [X] deceased) [X] attended the deceased from 12/23, 19 88, to 12/27, 19 88, that (I) (we) last saw the deceased alive on 12/23, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) [X] did [ ] did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | 22c. DATE SIGNED |
|---|---|---|---|---|
| Kathryn Siena Kirwin | MD | ATTENDING PHYSICIAN [ ] | MEDICAL DIRECTOR [X] | STAFF PHYSICIAN [ ] 12/27/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| KATHRYN SIENA KIRWIN MD | Suite 606 10400 Connecticut Ave, Kensington, MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12-28-88 | Mt. Lebanon Cemetery | Adelphi, Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Ives-Pearson Funeral Homes | Falls Church, Va. 22046 | DEC 29 1988 | Julia Davidson-Randall |

016522 DEC 16 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO 88 37089

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | FREDERICK D. HAIRSTON | 2a. DATE OF DEATH MONTH / DAY / YEAR | 12 / 08 / 88 | 2b. HOUR | 1140 A M |
| 3. SEX | M | 4. RACE | BLACK | 5. DATE OF BIRTH MONTH / DAY / YEAR | Feb. 20, 1950 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 38 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS: HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | N. CAROLINA | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH | Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Holy Cross Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | COUNSELOR |
| 12b. KIND OF BUSINESS OR INDUSTRY | Psych. Clinic | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | MARYLAND | 13b. COUNTY | PR. George | 13c. CITY OR TOWN | Temple Hills |
| 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS | 5606 Holton Lane | | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | EARLIE T HAIRSTON | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | MAGGIE Pullium | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | NO | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | 243-74-5231 |
| 17. INFORMANT | AUDREY WALKER | ADDRESS | 5606 Holton Lane Temple Hills, MD. | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CACHEXIA / RESPIRATORY FAILURE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) ACQUIRED IMMUNEDEFICIENCY SYNDROME

DUE TO, OR AS A CONSEQUENCE OF (c) HIV INFECTION

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): HERPES SIMPLEX, SYPHILIS

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED | 12-8-88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PHUONG D. TRINH | 22e. ADDRESS 8630 FENTON ST. #230 SILVER SPRING MD | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Burial | 23b. DATE | 12-11-88 | 23c. NAME OF CEMETERY OR CREMATORY: Levington Mem. |
| 23d. LOCATION CITY OR TOWN | Levington | COUNTY | N.C. | STATE |
| 24. FUNERAL DIRECTOR NAME | Nelson E. Greene | ADDRESS | GREENE FUNERAL HOME, INC. 814 FRANKLIN STREET ALEXANDRIA, VIRGINIA 22314 | 25a. DATE REC'D. BY REGISTRAR: DEC 14 1988 |
| 25b. REGISTRAR'S SIGNATURE | Julia Davidson-Randall | | | |

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 37090

01656 DEC 1988

1. DECEASED NAME (TYPE OR PRINT): First Sydney Middle H. Last Haken

2a. DATE KNOWN OF DEATH / ESTIMATED: Dec 12 19 88 — 2b. HOUR: 12 PM

3. SEX: M — 4. RACE: W — 5. DATE OF BIRTH: Month Jan. Day 1 Year 1910 — 6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min.

2c. DATE PRONOUNCED DEAD: Dec 12 19 88 — 2d. HOUR: 12 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York — 7b. CITIZEN OF WHAT COUNTRY?: USA — 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] — 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD

10. CITY OR TOWN OF DEATH: Silver Spring — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Sales — 12b. KIND OF BUSINESS OR INDUSTRY: Hecht's

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md — 13b. COUNTY: Mont. — 13c. CITY OR TOWN: Silver Spg — 13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS: 2917 Sundale Dr.

14. FATHER'S NAME: First Moses Middle Last Haken — 15. MOTHER'S MAIDEN NAME: First Betti Middle Last Gold

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): WWII — 16b. SOCIAL SECURITY NO.: 108 03 1197 — 17. INFORMANT ADDRESS: Ruth Haken (Wife) same as #13

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Dis.
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Myocardial Dis.
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: John Rogers M.D. — TITLE (SPECIFY): MD — MEDICAL EXAMINER — DATE SIGNED: Dec 12, 1988

EXAMINER'S NAME (TYPE OR PRINT): John Rogers, M.D. — ADDRESS: Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL: Burial — 23b. DATE: Dec.13,1988 — 23c. NAME OF CEMETERY OR CREMATORY: Beth David Cemetery — 23d. LOCATION CITY OR TOWN: Elmont COUNTY: New York STATE

24. FUNERAL DIRECTOR NAME: Ives-Pearson Funeral Homes — ADDRESS: Falls Church, Va. 22046 — 25a. DATE REC'D. BY REGISTRAR: DEC 16 1988 — 25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DHMH 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))

J19036 JAN 13 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 37091
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 10

DHMH - 16 60M 7/84 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Helen M. Hale | | | | 2a. DATE OF DEATH MONTH DAY YEAR: 12/24/88 | 2b. HOUR: 10:15AM |
| 3. SEX: female | 4. RACE: white | 5. DATE OF BIRTH MONTH DAY YEAR: 02/03/12 | 6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH: Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Carriage Hill Nursing Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): secretary | 12b. KIND OF BUSINESS OR INDUSTRY: gov't | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Montgomery | 13c. CITY OR TOWN: Silver Spring | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS / ZIP CODE: 9509 Saginaw Ave. 20910 | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST: GEORGE / E. / MEADOR | | | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: BESSIE / L. / FREEMAN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 220-28-6412 | 17. INFORMANT: JOHN R. HALE SON | ADDRESS: 19121 WINDSOR FOREST RD MT. AIRY, MD 21771 | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiopulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12/24/88
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Recurrent Aspiration — 12/88
DUE TO, OR AS A CONSEQUENCE OF (c): Gastric Ulcer, Benign — 12/88

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Anemia, ASCVD, CVA

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: None | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☒ |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): No | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 1982, 19____, to 12/24/88, 19____, that (I) (we) last saw the deceased alive on 12/24/88, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: DBPatrick III MD — DEGREE: ATTENDING PHYSICIAN ☒ / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/24/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. George Patrick, III MD

22e. ADDRESS: 9221 Colesville Rd. Sil. Spr., MD 20910

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: DEC 28, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: PARKLAWN CEMETERY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: ROCKVILLE MONTGOMERY MARYLAND |

24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR.
ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901

25a. DATE RECEIVED BY REGISTRAR: DEC 27 88

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

016489 DEC 16 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

REG. NO. 88 037092

| | | | |
|---|---|---|---|
| DECEASED NAME (TYPE OR PRINT) FIRST: Rixey MIDDLE: T. LAST: Hansborough, Sr | 2a. DATE OF DEATH MONTH DAY YEAR: 12/11/88 | 2b. HOUR: 5:08p M | |
| 3. SEX: Male | 4. RACE: black | 5. DATE OF BIRTH MONTH DAY YEAR: 11 16 96 | 6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS; IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VA | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARITAL: MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONT MD. |
| 10. CITY OR TOWN OF DEATH: Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): UNK | 12b. KIND OF BUSINESS OR INDUSTRY: NAVY |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| maryland | Montgomery | Silver Spring | YES ☑ NO ☐ | 9101 second street 20910 |

| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | |
|---|---|---|
| FIRST EDWARD MIDDLE LAST HANSborough | FIRST LARINIA MIDDLE TRIPPLET LAST | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | | 579-60-4278 | William BRAXTON/NEPHEW | 4416 20th St |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Acute Cardiopulmonary Arrest | 12/11/88 |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Acute Pneumonia (R) lung | 12/10/88 |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Dehydration | 12/10/88 |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CHF, COPD, ASCVD, Cardiac arrythmia

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| None | | YES ☐ NO ☑ | YES ☐ NO ☑ |

| 21a. ACCIDENT WAS UNDERLYING AND/OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| NO | | |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | | |

22a. I certify that (I) (~~this hospital~~) attended the deceased from 11/17/88, 19____, to 12/11/88, 19____, that (I) (~~ev~~) last saw the deceased alive on 12/11/88, 19____, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above (I) (~~we~~) (did) (~~did not~~) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| GBPatrick III MD | ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/11/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| GBPatrick III MD | 9221 Colesville Rd Silver Spring, Md 20910 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 12-17-88 | EBENEZER CHURCH | LIGNUM, VA |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| JOHN T RHINES Co, 3015 12th St NE | DEC 15 1988 | Julia Davidson-Randall |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

018459 JAN 0 8 89

B 8 3 7 0 9 3 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST: Rose | MIDDLE: C. | LAST: Hardesty | |
| 2a. DATE OF DEATH | MONTH: 12 | DAY: 15 | YEAR: 88 | 2b. HOUR: 3 PM |
| 3. SEX: F | 4. RACE: Caucasian | 5. DATE OF BIRTH: 05-24-14 | 6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): ILLINOIS | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH: Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Colonial Villa Nursing Home | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND | 13b. COUNTY: MONTGOMERY | 13c. CITY OR TOWN: SILVER SPRING | 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] | 13e. STREET ADDRESS: 10149 BROOKMOOR DRIVE 20901 |
| 14. FATHER'S NAME: FIRST FRANCO MIDDLE LAST ESPOSITO | | 15. MOTHER'S MAIDEN NAME: FIRST AGATA MIDDLE LAST BELLECE | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 578-03-1800 | 17. INFORMANT: DAUGHTER DONNA M. CLARKE | ADDRESS: 9003 LINTON STREET SILVER SPRING, MD 20901 | |

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Squamous Cell Lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 11/14/88 19 88 to 12/15 19 88, that (I) (we) last saw the deceased alive on 12/15 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 15 Dec 88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Michael Leibach, MD — 22e. ADDRESS: 11120 Main St, Md 20904

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: DEC 19, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: PARKLAWN CEMETERY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: ROCKVILLE MONTGOMERY MD | |
| 24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901 | | 25a. DATE RECD. BY REGISTRAR: DEC 16 1988 | 25b. REGISTRAR'S SIGNATURE: [signature] | |

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 37094

18460 JAN -9 89

DECEASED NAME (TYPE OR PRINT): First: Robert; Middle: ; Last: Hare

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month/Day/Year: 12/9 19 88

2b. HOUR: M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: Month/Day/Year: July 3, 1901

6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS. IF UNDER 1 YR. MONTHS: DAYS: IF UNDER 24 HRS. HOURS: MIN.:

2c. DATE PRONOUNCED DEAD: Month/Day/Year: 12/9 19 88

2d. HOUR: 5:30 P. M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): KANSAS

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARITAL STATUS: MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 3310 Chiswick Court

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ADMINISTRATOR

12b. KIND OF BUSINESS OR INDUSTRY: USCSC

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Silver Spring

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 3310 Chiswick Court 20901

14. FATHER'S NAME: First: STUART; Middle: ; Last: HARE

15. MOTHER'S MAIDEN NAME: First: PRISCILLA; Middle: ; Last: HOLDSWORTH

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES): --------

16b. SOCIAL SECURITY NO.: 577-60-4631

17. INFORMANT: WENDELL McCAIN

ADDRESS: 7002 17th AVE. SEATTLE, WASH.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute myocardial disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): chronic myocardial disease.

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): None

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Noturol couses [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: John S. Rogers M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 12/10/88

EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers, M.D. ADDRESS: 1919 Seminary Road Silver Spring, Montgomery County, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION

23b. DATE: 12-13-1988

23c. NAME OF CEMETERY OR CREMATORY: CHAMBERS CREMATORY

23d. LOCATION CITY OR TOWN: RIVERDALE, COUNTY: P.G.C. STATE: Md.

24. FUNERAL DIRECTOR NAME AND ADDRESS: W. W. CHAMBERS CO. INC., SILVER SPRING, Md. 20910

25. DATE RECEIVED BY REGISTRAR: DEC 16 88

25. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 2 AND 2E SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIMH - 17 REV. A15 ME (5)1

018084 JAN 4 89

Item #'s 18a, 22a per med 2/9/89

FOR 1- STATE REGISTRAR Film G648 cg

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 37095

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | | | | | | 2a. DATE KNOWN OF DEATH / ESTIMATED | MONTH | DAY | YEAR | 2b. HOUR |
| Charles | Alvin | Harriott | | | | | | XX | 12- | 8- | 19 88 | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. | 2c. DATE PRONOUNCED DEAD | 12- | 8- | 19 88 | 2d. HOUR M |
| Male | Black | 4-3-51 | 37 YRS. | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Virginia | U.S.A. | | | | | | | Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Silver spring | 8484 16th Street #801 | | | | | | | Comp. Programmer | | | | Dist. Gvt. |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montg. | Silver Sprng | YES ☒ NO ☐ | 8484 16th St. |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Unknown | | | Theader | Mae | Brown |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 231-80-8086 | Theater Brown | 3200 16th St.N.W. D.C.20010 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Arteriosclerotic cardiovascular disease | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. — DUE TO, OR AS A CONSEQUENCE OF (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES XX NO ☐ |

| 21a. EXTERNAL CAUSE WAS | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 19 | |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | | | | | |

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE John E. Smialek M.D. TITLE (SPECIFY) Chief MEDICAL EXAMINER DATE SIGNED 12-9-88

VC EXAMINER'S NAME (TYPE OR PRINT) JOhn E. Smialek,M.D. ADDRESS 111 Penn Street,Baltimore,MD 21201

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | 12/15/88 | Christian Hill Ch. | Halifax, | | Va. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Horton Funeral Home | 600 Kennedy St.NW Washington, D.C. | DEC 29 1988 | Julia Davidson-Randall |

07/84 25M BP 236

DHMH - 17 (VR A15 ME (5))

016106 DEC 14 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the local registrar of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 36 50M 1/81
(VRA 15, 4)

FOR 1 - STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

88 37096
REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Bradley | Middle: G | Last: Harrison | 2a. DATE OF DEATH Month: 12 Day: 10 Year: 88 | 2b. HOUR 9:16 AM | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH Month: 12 Day: 10 Year: 88 | 6. AGE (IN YEARS LAST BIRTHDAY): NB. YRS. | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS Hours / Min. 39 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH: Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): N/A | 12b. KIND OF BUSINESS OR INDUSTRY | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Florida | | Maitland | YES ☒ NO ☐ | 2601 Chippewa Trail |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last |
|---|---|
| Thomas A Harrison | Cathryn Cook |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|---|
| N/A | | N/A | Robert Cook 901 Downs Dr. S.S. Md. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiorespiratory arrest | 15 minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Pulmonary insufficiency | 37 minutes |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Prematurity

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☒ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from December 10, 19 88, to Dec 10, 19 88, that (I) (we) last saw the deceased alive on Dec 10, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE / DEGREE | 22c. DATE SIGNED |
|---|---|
| Asa Hamosh MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ | 12/10/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| HAMOSH | 1500 Forest Glen Rd, Silver Spring MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12/13/88 | Gate of Heaven | S.S. / Mont. / Md. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md | DEC 13 1988 | Julia Brown-Rodgers |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

017411 DEC 28 88

1- FOR STATE REGISTRAR Donald A. Harrison

REG NO. 5 3 5 0 9 7

DECEASED NAME (TYPE OR PRINT): FIRST Donald MIDDLE A. LAST Harrison

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ MONTH Dec DAY 22 YEAR 1988 — 2b. HOUR 12:15 AM

3. SEX M — 4. RACE W — 5. DATE OF BIRTH: MONTH June DAY 15,1 YEAR 1920 — 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH Dec DAY 22 YEAR 1988 — 2d. HOUR 12:45 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Missouri — 7b. CITIZEN OF WHAT COUNTRY? USA — 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD

10. CITY OR TOWN OF DEATH: Olney — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Mont. General Hosp — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Elec. Engineer — 12b. KIND OF BUSINESS OR INDUSTRY: I.B.M.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: Mont. — 13c. CITY OR TOWN: Gaithersburg — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: 20951 Lochaven Ct. 20879

14. FATHER'S NAME: Charles - Harrison — 15. MOTHER'S MAIDEN NAME: Corinne - Aquart

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WWII — 16b. SOCIAL SECURITY NO.: 548-26-6897 — 17. INFORMANT: Mary B. Harrison — ADDRESS: Same as #13

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarct
DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic Myocardial Dis.
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): None

19a. DATE OF OPERATION: None — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] TITLE (SPECIFY) M.D. Dr. MEDICAL EXAMINER — DATE SIGNED Dec. 22, 1988

EXAMINER'S NAME (TYPE OR PRINT) Dr. John R. Rogers — ADDRESS Silver Spring. Md. 20901

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: Dec. 23, 1988 — 23c. NAME OF CEMETERY OR CREMATORY: Norbeck Mem. Park — 23d. LOCATION CITY OR TOWN: Olney COUNTY: Mont. STATE: Md.

24. FUNERAL DIRECTOR NAME: Muriel H. Barber — ADDRESS: Laytonsville, Md. 20879 — 25a. DATE REC'D. BY REGISTRAR: DEC 27 1988 — 25b. REGISTRAR'S SIGNATURE [signature]

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

016543 DEC 1988 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37093 REG. NO

| 1. DECEASED NAME (TYPE OR PRINT) | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
|---|---|---|---|---|---|---|---|---|
| | Ida | Mae | Harrison | | 12/5/88 | | | 6:55AM M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
|---|---|---|---|---|---|---|---|
| | | MONTH DAY YEAR | | MONTHS | DAYS | HOURS | MIN. |
| Female | Black | 4 25 1912 | 76 YRS. | | | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| S.Carolina | U.S.A. | MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐ | Montgomery MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Wheaton | University Convalescent Home | Domestic | None |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Pr. George | Lanham | YES X NO ☐ | 5403 85th Ave, 20706 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Willis | | Gilliams | Carrie | | Coats |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 579-30-7671 | Mrs Lillie Fortune (Daughter) | Address Same. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.

DUE TO, OR AS A CONSEQUENCE OF (b) cerebral nascular accident — 3 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I) (this hospital) attended the deceased from 11/24 19 86 to 12/5 19 88, that (I) (we) last saw the deceased alive on 11/14/88 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
|---|---|---|---|
| Myron L. Lenkin MD | | ATTENDING PHYSICIAN X MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Myron L. Lenkin, M.D. | 2309 Shorefield Rd., Wheaton, MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Burial | 12-10-88 | Md National Park | Laurel, Pr George, Md |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| George R. Snowden | Rockville, MD20850 | DEC 6 '88 | Julia Davidson-Rondelle |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN:

BP 5

DHMH - 16 60M 7/84 (VRA 15, 4)

0175776 DEC 30 88

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 037100

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| MICHAEL | JOSEPH | HAURY | DECEMBER 7, 1988 | 8:15A.M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | CAUCASIAN | SEPTEMBER 30,1970 | 18 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| VIRGINIA | UNITED STATES | MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | MONTGOMERY COUNTY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| BETHESDA | NIH, THE CLINICAL CENTER | STUDENT | HIGH SCHOOL |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| VIRGINIA | GLOUCESTER | GLOUCESTER POINT | YES ☐ NO ☒ | POST OFFICE BOX 89 /23062 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| E. | EARL | HAURY, JR. | JOAN | | SUTTON |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 229-90-2777 | JOAN HAURY | SAME AS #13 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | MASSIVE PULMONARY HEMORRHAGE | 1 HOUR |
| DUE TO, OR AS A CONSEQUENCE OF (b) | ASPERGILLUS/FUSARIUM INFECTION | 3 WEEKS |
| DUE TO, OR AS A CONSEQUENCE OF (c) | APLASTIC ANEMIA | 2 MONTHS |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☒ NO ☐ | YES ☒ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that I (this hospital) attended the deceased from October 10, 19 88, to December 7, 19 88, that I (we) last saw the deceased alive on December 7, 19 88, and that I (we) (did) (did not) view the body after death. (and that in my (our) opinion death occurred on the date and hour and from the causes stated above.)

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ | 12.7.88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Chris Johnson | NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | DECEMBER 10, 1988 | ROSEWELL MEMORIAL GARDEN | GLOUCESTER COUNTY/VIRGINIA |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland | DEC 9 '88 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

P

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

016557 DEC 1988

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 88 37101

1a. DECEASED NAME (TYPE OR PRINT): FIRST MARY; MIDDLE CHRISTINE; LAST HEALY

2a. DATE OF DEATH: MONTH 12 DAY 11 YEAR 88

2b. HOUR 7 10 A M

3. SEX: FEMALE

4. RACE: CAUCASIAN

5. DATE OF BIRTH: MONTH 1 DAY 3 YEAR 1911

6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS

IF UNDER 1 YEAR: MONTHS — DAYS —

IF UNDER 24 HRS: HOURS — MIN. —

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD.

7b. CITIZEN OF WHAT COUNTRY? U.S.A

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SHADY GROVE ADVENTIST Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): NURSE —

12b. KIND OF BUSINESS OR INDUSTRY: HOSPITAL

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD.

13b. COUNTY: MONTGOMERY

13c. CITY OR TOWN: GERMANTOWN

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS: 12531 CRYSTAL ROCK TR./20684

14. FATHER'S NAME: FIRST ARTHUR; MIDDLE R.; LAST MIDDLETON

15. MOTHER'S MAIDEN NAME: FIRST CHRISTINA; MIDDLE M.; LAST LLOYD

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 217-72-7846

17. INFORMANT: JEAN M. FINELLI, 10110 WHITE AVE, CLINTON, MD. ADDRESS 20735

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): RESPIRATORY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF

(b): PNEUMONIA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c): CEREBRAL VASCULAR Accident

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

HYPERTENSION - HEMIPLEGIA

19a. DATE OF OPERATION: —0—

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —0—

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2): — N.A —

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.): — N.A —

21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from NOV 19 88 to 12-10 19 88, that (I) (we) last saw the deceased alive on 12-10 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~last~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: [signature] DEGREE M.D. ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED 12/11/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): BERREBI MD

22e. ADDRESS: 17904 GEORGIA AVE, OLNEY MD 20832

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 12-15-88

23c. NAME OF CEMETERY OR CREMATORY: ST. JOSEPH'S CEMETERY

23d. LOCATION: CITY OR TOWN MORGANZA; COUNTY St. Mary's; STATE MD.

24. FUNERAL DIRECTOR: NAME MATTINGLEY FUNERAL HOME, ADDRESS LEONARDTOWN, MD. 20650

25a. DATE RECD. BY REGISTRAR: DEC 16 1988

25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

018342 JAN -6 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81 (VRA 15, 4)

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

1 - FOR STATE REGISTRAR

REG. NO. 88 037102

1a. DECEASED NAME (TYPE OR PRINT): FIRST Florence MIDDLE May LAST Heffer

2a. DATE OF DEATH: MONTH 12 DAY 20 YEAR 88

2b. HOUR: 6:25 AM

3. SEX: Female

4. RACE: white

5. DATE OF BIRTH: MONTH 10 DAY 21 YEAR 99

6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PA

7b. CITIZEN OF WHAT COUNTRY?: U.S.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Rockville, Md.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Potomac Valley Nursing Home

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): housewife

12b. KIND OF BUSINESS OR INDUSTRY: own home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Allegany

13c. CITY OR TOWN: Cumberland

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: Industrial Blvd./21502

14. FATHER'S NAME: FIRST Alfred MIDDLE E. LAST Howe

15. MOTHER'S MAIDEN NAME: FIRST Mary MIDDLE Reese LAST Harlan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES): 213-74-1195

17. INFORMANT: Wm. Birmingham ADDRESS: 14372 Woodcrest Dr. Rockville, Md. 20853

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: immediate

DUE TO, OR AS A CONSEQUENCE OF (b): Pneumonia — 3 days

DUE TO, OR AS A CONSEQUENCE OF (c): Cerebrovascular accident — 2 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 6/3/86, 19 86, to 12/20, 19 88, that (I) (we) last saw the deceased alive on 12/19, 19 88, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.

22b. SIGNATURE: Lee R. Pennington DEGREE: M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12/20/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Lee R. Pennington, M.D.

22e. ADDRESS: 8210 Wisconsin Ave, Bethesda, Md. 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 12-22-1988

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION: CITY OR TOWN Cumberland COUNTY Allegany STATE MD

24. FUNERAL DIRECTOR: NAME, ADDRESS: James F. Scarpelli, Cumberland, MD 21502

25a. DATE REC'D. BY REGISTRAR: DEC 21 1988

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 5

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 REG. NO. 037103

1 - FOR STATE REGISTRAR

016680 DEC 2088

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Hilda — MIDDLE: Alice — LAST: Heming
2a. DATE OF DEATH — MONTH DAY YEAR: December 16, 1988
2b. HOUR: 4:00 P M
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH — MONTH DAY YEAR: November 10, 1916
6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Canada
7b. CITIZEN OF WHAT COUNTRY?: United States
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.
10. CITY OR TOWN OF DEATH: Rockville
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 12604 St. James Road
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker
12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Rockville
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS / ZIP CODE: 12604 St. James Road / 20850

14. FATHER'S NAME — FIRST MIDDLE LAST: George Arthur Clinton
15. MOTHER'S MAIDEN NAME — FIRST MIDDLE LAST: Nancy French
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES):
16b. SOCIAL SECURITY NO.: 381-10-3131
17. INFORMANT — ADDRESS: Arthur E. Heming, Same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC ARREST, RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b): METASTATIC ENDOMETRIAL CELL CARCINOMA
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): MALIGNANT REVIAL, PERICARDIAL AND PERITONEAL EFFUSIONS

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from MAY, 19 87, to December 16, 19 88, that (I) (we) last saw the deceased alive on DECEMBER 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: December 17, 1988
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Irving Mizus, M. D.
22e. ADDRESS: #206 C 5413 Cedar lane, Bethesda, MD 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 12-20-88
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Memorial Park
23d. LOCATION — CITY OR TOWN COUNTY STATE: Rockville, Maryland
24. FUNERAL DIRECTOR NAME AND ADDRESS: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910
25a. DATE REC'D BY REGISTRAR: DEC 19 1988
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or there is shown any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

019746 JAN 1989

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37104
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

BP 10

DHMH - 16 60M 7/84
(VRA 15, 4)

| 1. DECEASED NAME (TYPE OR PRINT) | FIRST | MIDDLE | LAST |
|---|---|---|---|
| | Edna | M. | Henderson |

| 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
|---|---|---|---|---|
| | 12 | 26 | 88 | 6:45 p M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | MONTH | DAY | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN. |
|---|---|---|---|---|---|---|---|---|---|---|
| Female | CAU | | 11 | 3 | 94 | 94 YRS. | | | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| md | USA | | Montgomery County MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Olney | Brooke Grove N.H. | Housewife. | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Md. | Mont. | SILVER SPRING | YES ☒ NO ☐ | 3410 GLENEAGLES DRIVE 20906 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| JOSEPH | A. | SWOPE | MARY | L. | HARDEN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 577-84-1860 | JOSEPH A. SLIFER SON | SAME AS 13 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CARDIAC - ARREST | 5 MIN |
| DUE TO, OR AS A CONSEQUENCE OF (b) | CONGESTIVE HEART FAILURE | 2 HOURS |
| DUE TO, OR AS A CONSEQUENCE OF (c) | ACUTE RENAL FAILURE. | 3 WEEKS |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

ADVANCED AGE, UREMIA

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (~~this hospital~~) attended the deceased from MAY 31, 19 84, to DEC 26, 19 88 that (I) (we) last saw the deceased alive on 12-21-88, 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did) (~~did not~~) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Elvin Adams, MD | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ | 12-26-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| ELVIN ADAMS, M.D. | 6930 CARROLL AVE, TAKOMA PARK 20912 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| BURIAL | DEC. 29, 1988 | FT. LINCOLN CEMETERY | BRENTWOOD | PR. GEO. | MARYLAND |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| FRANCIS J. COLLINS, JR. | 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901 | DEC 29 '88 | Julia Davidson-Randall |

016542 DEC 1988 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37105 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Ralph | MIDDLE | LAST: Henry | 2a. DATE OF DEATH MONTH: Dec | DAY: 1, | YEAR: 88 |
| 2b. HOUR: M | | | | | |
| 3. SEX: Male | 4. RACE: Black | 5. DATE OF BIRTH MONTH DAY YEAR: 4-23-1902 | 6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH: Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Grosvenor Health Care Center | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Truck Driver | 12b. KIND OF BUSINESS OR INDUSTRY: None | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD | 13b. COUNTY: Montg. | 13c. CITY OR TOWN: Rockville | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET ADDRESS / ZIP CODE: 714 Lenmore Ave./20850 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST: Ulysses Henry | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Della? | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 216-14-0020 | 17. INFORMANT: Thomas Henry (Bro.) | ADDRESS: 5721 Grosvenor Lane Bethesda, MD | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF (c) CARDIOMYOPATHY.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Urinary Infection. Old CVA c Right HEMIPLEGIA

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: NA | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: NA | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☒ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: NA | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2): NA | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ NA | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.): NA | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from June 19 85 to Dec 19 88 that (I) (we) last saw the deceased alive on Nov. 29 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Kamalina V. Deshpande MD DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12-1-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): KAMALINA V. DESHPANDE — 22e. ADDRESS: 6001 Lux Lane Rockville, MD 20852

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12-5-88 | 23c. NAME OF CEMETERY OR CREMATORY: Mt. Pleasant Cem. | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Gaithersburg, Montg. MD | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: George R. Snowden Rockville, MD 20850 | 25a. DATE REC'D. BY REGISTRAR: DEC 6 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rondelle | | |

016444 DEC 15 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 37106

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| SIDNEY | | HEYMAN | 12 8 88 | 11:30 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN. |
|---|---|---|---|---|---|
| Male | White | 7 4 08 | 80 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| New York | US | MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | MONTG MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| SILVER SPRING | HOLY CROSS HOSP | Gen. Manager (Ret.) | Pabst Beer Dis |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | P.G. | ADELPHI | YES ☐ NO ☐ | 1836 METZEROTT RD (20783) |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Albert | | Heyman | Ida | | Cohen |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| YES | WWII | 157-12-3004 | Lauri Bilawa; Niece; 24 Yeatman Court; Silver | Spring, Md. 20902 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) PULMONARY EDEMA AND CARDIOPULMONARY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 Hr

DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): RENAL FAILURE

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 12/5 19 88 to 19 , that (I) (we) last saw the deceased alive on 12/8 19 88 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | 22c. DATE SIGNED |
|---|---|---|---|---|
| Thos H. Burgueres | MD | ATTENDING PHYSICIAN ☐ | MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ | 12/9/88 3 AM |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| THOMAS H. BURGUIERES | HOLY CROSS HOSP. E.R. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12/11/88 | King David Mem. Garden | Falls Church; Fairfax; Va. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852 | DEC 14 1988 | |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner shall be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1650M 1/81 (VRA 15, 4)

017577 DEC 30 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37107 REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Richard Middle: D. Last: Hickman | | | | 2a. DATE OF DEATH Month Day Year: 12-7-88 | 2b. HOUR: 1400 M |
| 3. SEX: male | 4. RACE: Caucasian | 5. DATE OF BIRTH Month Day Year: 5 25 06 | | 6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS | If under 1 year: Months / Days; If under 24 hrs: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH: Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hosp | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Engineer | 12b. KIND OF BUSINESS OR INDUSTRY: Steel Structural |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| md | Montgomery | Gaithersburg | YES ☒ NO ☐ | 772 Tiffany Drive/20878 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last |
|---|---|
| Edward / Lee / Hickman | Elizabeth / -- / Keeling |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | --- | 577-10-9319 | John R. Hickman, Same address as #13. |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | Approximate interval between onset and death |
|---|---|---|
| IMMEDIATE CAUSE (a) | Sepsis | 1 wk |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Urinary tract infection | 1 wk |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Prostate cancer | 5 yrs |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Anemia

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☒ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 11/29 19 88 to 12/7 19 88, that (I) (we) last saw the deceased alive on 12/7 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
|---|---|---|---|
| Peter Sherer | md | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/8/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Peter B. Sherer md | 3947 Ferrara Dr. Wheaton, md 20906 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12/12/88 | New Cathedral Cem. | Baltimore, MD |

| 24. FUNERAL DIRECTOR (NAME) / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016 | DEC 14 '88 | Julia Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

D19035 JAN 13 89

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 REG. NO. 37108

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | JULIE / C. / HILLOW | 2a. DATE OF DEATH MONTH DAY YEAR | DECEMBER 24, 1988 |
| 2b. HOUR | 7:15P M | | |
| 3. SEX | FEMALE | 4. RACE | CAUCASIAN |
| 5. DATE OF BIRTH MONTH DAY YEAR | SEPT 25 1908 | 6. AGE (IN YEARS LAST BIRTHDAY) | 80 YRS |
| IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS. HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | WASHINGTON, DC | 7b. CITIZEN OF WHAT COUNTRY? | USA |
| 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | | 9. BALTIMORE CITY OR COUNTY OF DEATH | MONTGOMERY MD. |
| 10. CITY OR TOWN OF DEATH | SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | HOLY CROSS HOSPITAL |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MARYLAND | MONTGOMERY | SILVER SPRING | YES [ ] NO [ ] | 910 BENSON TERRACE 20901 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| GEORGE / / TEHAAN | TAMMAN / / UNKNOWN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | | SAMUEL J. HILLOW/HUSBAND/SAME AS 13 | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Acute myocardial infarction | Immediate |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Hypertensive arteriosclerotic cardiovascular disease | 20 years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (~~this hospital~~) attended the deceased from Oct 5, 1951, to Dec. 27, 1988, that ~~I~~ (we) last saw the deceased alive on Dec. 24, 1988, and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (~~did not~~) view the body after death.

| 22b. SIGNATURE DEGREE | ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED |
|---|---|---|
| Raymond Bradshaw, MD | | 12/26/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Raymond Bradshaw, Jr. MD | 345 University Blvd, W Silver Spring, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | DEC 28, 1988 | GLENWOOD CEMETERY | WASHINGTON, DC |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | ACCEPTED BY REGISTRAR'S SIGNATURE |
|---|---|
| FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901 | DEC 27 88 Gina Davidson-Randall |

18282 JAN-6 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CHMH - 16 50M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH** 88 37109 REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| REBA | H. | HIMMELFARB | January 2, 1989 | 0400 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Female | Caucasian | January 15, 1918 | 70 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Balt., Maryland | U.S.A. | | Montgomery County, MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Chevy Chase | 4701 Willard Avenue, #1529 | Homemaker | Home |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Chevy Chase | YES ☐ NO ☐ | 4701 Willard Avenue 20815 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| DAVID | | SCHULMAN | LENA | | KAPLAN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | -------- | 578-12-6848 | Franklin Himmelfarb; Son | 12722 Saddlebrook Drive; Silver Spring, Md. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Myocardial Infarction | minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Arteriosclerotic heart disease | years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from MAY, 19 75, to 1/2, 19 89, that (I) (we) last saw the deceased alive on 1/25, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| | ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | Jan. 3, 1989 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DONALD A. O'KIEFFE M.D. | 5530 Wisconsin Ave., #509; Chevy Chase, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 1/5/89 | Judean Memorial Garden | Olney; Montgomery; Maryland |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852 | JAN 5 1989 | Gina Davidson-Randall |

01604 (8) DEC 4 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 33 37110

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Eugene | Middle: Wayne | Last: Hoelscher | 2a. DATE OF DEATH Month/Day/Year: 12/3/88 | 2b. HOUR: 12:25 A M | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH Month/Day/Year: 2/16/65 | 6. AGE (IN YEARS LAST BIRTHDAY): 23 YRS | # UNDER 1 YEAR Months/Days | # UNDER 24 HRS Hours/Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington DC | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH: TAKOMA PARK. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST HOSP. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Cook | 12b. KIND OF BUSINESS OR INDUSTRY: Restaurant | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD | 13b. COUNTY: P.G. | 13c. CITY OR TOWN: HYATTSVILLE | 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ | 13e. STREET ADDRESS: 6002 41st AVE 20782 | |
| 14. FATHER'S NAME First: Eugene | Middle: Paul | Last: Hoelscher | 15. MOTHER'S MAIDEN NAME First: Evelyn | Middle: Pauline | Last: Wilson |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): ---------- | 16b. SOCIAL SECURITY NO.: 219-06-0780 | 17. INFORMANT ADDRESS: Eugene P. Hoelscher, Same as line #13 | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): respiratory failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b): metastatic sarcoma

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from June 19 88 to 12/2 19 88, that (I) (we) last saw the deceased alive on 12/2 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death.

22b. SIGNATURE: Marlin O. Weltz DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/3/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Marlin O. Weltz — 22e. ADDRESS: 7525 Greenway Cir Drive Greenbelt MD

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12-08-88 | 23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Brentwood, P.G., Maryland | |
| 24. FUNERAL DIRECTOR NAME AND ADDRESS: FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland | 25a. DATE REC'D BY REGISTRAR: DEC 5 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

19754 JAN 1989

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37111 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 2 and the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | William R. Hood | 2a. DATE OF DEATH MONTH DAY YEAR | December 25, 1988 |
| 2b. HOUR | M | | |
| 3. SEX | Male | 4. RACE | Black |
| 5. DATE OF BIRTH MONTH DAY YEAR | Apr. 23, 1895 | 6. AGE (IN YEARS LAST BIRTHDAY) | 93 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Maryland | 7b. CITIZEN OF WHAT COUNTRY? | USA |
| 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | | 9. BALTIMORE CITY OR COUNTY OF DEATH | MONTGOMERY MD. |
| 10. CITY OR TOWN OF DEATH | Beallsville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 19901 Beallsville Road |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Farmer | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | |
| 13a. STATE | MD | 13b. COUNTY | Montg. |
| 13c. CITY OR TOWN | Beallsville | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | |
| 13e. STREET ADDRESS / ZIP CODE | 19901 Beallsville Rd./ 20839 | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | William Hood | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Nettie Posey |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | No | (IF YES, GIVE WAR OR DATES) | |
| 16b. SOCIAL SECURITY NO. | 212-34-4439 | 17. INFORMANT | Ethel Moore (Daughter) |
| ADDRESS | 19920 Jerusalem Rd. Poolesville, MD | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO - RESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF (b) HEART FAILURE, CHRONIC

DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from Aug 83 to Sept 12, 19 88, that (I) (we) last saw the deceased alive on Sept 12, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | DEGREE MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED | 12-29-88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | ASUNCION, HECTOR | 22e. ADDRESS | 17600 W. Willard Road, Poolesville Maryland 20837 |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Burial | 23b. DATE | 12-29-88 | 23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery |
| 23d. LOCATION CITY OR TOWN / COUNTY / STATE | Dickerson, Montg. MD | | | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | George R. Snowden Rockville, MD 20850 | 25a. DATE REC'D. BY REGISTRAR | DEC 30 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

15882 DEC 12 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other trauma, the medical examiner must be notified also.

BP_____

DHMH - 16.60M 7/84 (VRA 15, 4)

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 37112

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR |
| KENNETH | EDWARD | HOWELL | DECEMBER 3, 1988 |

2b. HOUR: 10:00 AM

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | SEPTEMBER 7, 1966 | 22 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| TENNESSEE | UNITED STATES | MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | MONTGOMERY COUNTY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| BETHESDA | NIH, THE CLINICAL CENTER | DISABLED-US MARINES | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| TENNESSEE | MAURY | COLUMBIA | YES ☐ NO ☒ | 109 PLEASANT DR. 38401 |

99999

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| JOHN | | HOWELL | MILDRED | LOUISE | CLYMER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| YES | PEACETIME | 408-45-4271 | MRS. MILDRED HOWELL | 109 PLEASANT DR. COLUMBIA, TN 38401 |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | RESPIRATORY FAILURE | 1-10 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) | ADULT RESPIRATORY DISTRESS SYNDROME | 10 days |
| DUE TO, OR AS A CONSEQUENCE OF (c) | HODGKIN'S DISEASE | 15 months |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☒ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that ☒ (this hospital) attended the deceased from October 11, 19 88, to DECEMBER 3, 19 88, that ☒ (we) last saw the deceased alive on DECEMBER 3, 19 88, and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above. ☒ (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Chait Johsa | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ | 12-3-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Chait Johsa | NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | DEC. 7, 1988 | POLK MEMORIAL GDNS. | COLUMBIA, TENNESSEE |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| IVES-PEARSON FUNERAL HOMES | ARLINGTON, VIRGINIA | DEC 8 - 1988 | Jane Davidson-Randall |

9999

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

019033 JAN 1989

1 - FOR STATE REGISTRAR

REG. NO. 3711 3

| 1. DECEASED NAME (TYPE OR PRINT) | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ | MONTH | DAY | YEAR | 2b. HOUR |
|---|---|---|---|---|---|---|---|---|
| | JOHN | W. | HUFFSTETLER | | Dec. | 21, | 19 88 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. | 2c. DATE PRONOUNCED DEAD | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | NOV. 28, 1920 | 68 YRS. | | | | | DEC. 21 19 88 | 5:35 PM |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| N. CAROLINA | U.S.A. | | MONTGOMERY CO. MD |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| SILVER SPRING | 2832 SCHOOL HOUSE CIR. | RET. TECH. SGT. | U.S. A.F. |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Md. | MONTGOMERY | SILVER SPRING | YES ☒ NO ☐ | 2832 SCHOOL HOUSE CIR. 20902 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| JOHN | WESLEY | HUFFSTETLER | WINNIE | ELIZABETH | HANNAH |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| YES | WWII | 245-05-2811 | JOYCE A. HUFFSTETLER (SAME AS #13) |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Sequela of Myocardial Infarction

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

None

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE John S. Rogers M.D. TITLE (SPECIFY) Dep MEDICAL EXAMINER DATE SIGNED Dec 22 1988

EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. ADDRESS 1919 Seminary Road Silver Spring, Montgomery County, MD

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| BURIAL | 12-27-1988 | GEORGE WASH. CEM. | ADELPHI, | P.G.C. | MD. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| W. W. CHAMBERS CO. INC., | SILVER SPRING MD. 20910 | DEC 27 '88 | Julia Davidson-Randall |

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

01-84 25M

DHMH - 17 (VR A15 ME (5))

0184588 JAN -9

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37114 REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: MARY | MIDDLE: B. | LAST: HUGHES | 2a. DATE OF DEATH MONTH: DECEMBER DAY: 15 YEAR: 1988 | 2b. HOUR: 5:12P M | |
| 3. SEX: F | 4. RACE: C | 5. DATE OF BIRTH MONTH: OCT DAY: 02 YEAR: 1905 | 6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH: OLNEY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MONTGOMERY GENERAL HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Home | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | Montg. | SILVER SPRING | YES ☒ NO ☐ | 14506 FISKE DRIVE |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Harry | - | Fellows | Margaret | - | Unknown |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | ------- | 212-74-6165 | Carol Miller Md.Natl.Bk.PO.BOX.995 Balto.Md. 21203 |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF: (b) Respiratory insufficiency

DUE TO, OR AS A CONSEQUENCE OF: (c) Ruptured cancer

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 12-27-88 | Ruptured Cancer | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 11-26, 19 88, to 12-15, 19 88, that (I) (we) last saw the deceased alive on 12-15, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | 12-16-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| MARIO H. DIAZ M.D. | 18111 PRINCE PHILLIP DR OLNEY, MD 20832 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Cremation | 12/20/88 | Chambers Crematory | Riverdale | P.G. | Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| W.W.Chambers Co. Inc. | 5801 Cleveland Ave. Riverdale Md. 20737 | DEC 20 '88 | Julia Davidson-Randall |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

R BB

DHMH - 16 50M 1/81 (VRA 15, 4)

16232 DEC 15 88

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 37115
REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| ROBERT | JOHN | HUNSBERGER | 11-27-88 | 1:00a M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
|---|---|---|---|---|---|
| male | white | 07 28 1920 | 68 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Pennsylvania | U.S.A. | | Montgomery MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Rockville | 505 Mannakee Street | Manager | Dpt of Comm |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Rockville | YES XX NO ☐ | 505 Mannakee Street 20850 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| John | Shell | Hunsberger | Catherine | | O'Reilly |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | WW II | 164-18-1673 | Jean Hunsberger | 505 Mannakee St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF PROSTATE GLAND — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 YEARS
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: HEMOLYTIC UREMIC SYNDROME

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from MAY 7, 1987, to NOVEMBER 27, 1988, that (I) (we) last saw the deceased alive on NOVEMBER 10 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| James A. Brown | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 11/28/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| JAMES A. BROWN MD | 14808 PHYSICIANS LANE #212 ROCKVILLE MD 20850 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 01 DEC 88 | Gate of Heaven | Silver Spring, Mont, MD |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| DeVol Funeral Home Gaithersburg, MD | NOV 29 1988 | [signature] |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR — REG. NO. 37116

0184 — 9-89

1. DECEASED NAME (TYPE OR PRINT): FIRST Louise MIDDLE LAST Ingler
2a. DATE KNOWN OF DEATH ESTIMATED: MONTH Dec DAY 13 YEAR 1988 — 2b. HOUR 8:22 AM
3. SEX: F — 4. RACE: W — 5. DATE OF BIRTH: MONTH June DAY 10 YEAR 09 — 6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. — IF UNDER 1 YR.: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN
2c. DATE PRONOUNCED DEAD: MONTH Dec DAY 13 YEAR 1988 — 2d. HOUR 8:22 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MISSOURI
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD
10. CITY OR TOWN OF DEATH: S.S. Spg
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CLERK/SUPERVISOR
12b. KIND OF BUSINESS OR INDUSTRY: CIVIL SERVICE
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
13b. COUNTY
13c. CITY OR TOWN: WASHINGTON, DC
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS: 3636 16TH ST., NW 20010 99999
14. FATHER'S NAME: FIRST HUGH MIDDLE B. LAST INGLER
15. MOTHER'S MAIDEN NAME: FIRST ALICE MIDDLE LAST RAGSDALE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 577-60-4632
17. INFORMANT: NEPHEW CHARLES W. INGLER — ADDRESS: 2250 EAST DAVID RD DAYTON, OH 45440

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Dis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b): Chronic Myocardial Dis and
DUE TO, OR AS A CONSEQUENCE OF
(c): Aplastic Anemia

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.
None

19a. DATE OF OPERATION: None
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): Dept MEDICAL EXAMINER — DATE SIGNED: Dec 13 1988

EXAMINER'S NAME (TYPE OR PRINT): JOHN S. ROGERS, M.D. — ADDRESS: 1919 SEMINARY ROAD SILVER SPRING, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION — 23b. DATE: DEC. 17, 1988 — 23c. NAME OF CEMETERY OR CREMATORY: METROPOLITAN CREMATORY — 23d. LOCATION CITY OR TOWN: ALEXANDRIA COUNTY: VA STATE: VA

24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. — ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901

25. DATE RECEIVED BY REGISTRAR: DEC 19 1988 — 26. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

R

DHMH 17 (VR 315 AM (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 37117

REG. NO.

1 - FOR STATE REGISTRAR

3158 98 DEC 12

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1a. DECEASED NAME (TYPE OR PRINT) First: GERALD | Middle: | Last: ISELT. | 2a. DATE OF DEATH Month Day Year: 12-7-88 | 2b. HOUR: 11:39 PM | |
| 3. SEX: M | 4. RACE: W | 5. DATE OF BIRTH Month Day Year: 11-13-02 | 6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): TEXAS | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH: ROCKVILLE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HEBREW HOME OF GREATER WASH. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD. | 13b. COUNTY: MONTGOMERY | 13c. CITY OR TOWN: ROCKVILLE | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 6121 Montrose Rd. 20852 | |
| 14. FATHER'S NAME First: WILLIAM | Middle: ANDREW | Last: ISELT | 15. MOTHER'S MAIDEN NAME First: MOLLIE | Middle: MACKINNEY | Last: |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 558-16-2631 | 17. INFORMANT | ADDRESS | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Metastatic Prostatic Carcinoma — Approximate Interval Between Onset and Death: months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 11-2 19 88 to 12-7 19 88 that (I) (we) last saw the deceased alive on 12-7 19 88 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Loreto S. Albiol MD — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12-7-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): LORETO S. ALBIOL — Loreto S. Albiol MD — 22e. ADDRESS: 6121 montrose Rd.

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal | 23b. DATE: 12-8-88 | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE | |
| 24. FUNERAL DIRECTOR NAME: State Anatomy Board | ADDRESS: Balto., Md. | 25a. DATE REC'D. BY REGISTRAR: DEC 9 1988 | 25b. REGISTRAR'S SIGNATURE: Judith Davidson Hyndman | |

BP_____

DHMH - 16 50M 1/81
(VRA 15, 4)

17508 DEC 28 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 037113

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Kenneth | MIDDLE | LAST: Jacobson | 2a. DATE OF DEATH MONTH DAY YEAR: December 19, 1988 | 2b. HOUR: 5:00a M | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Sept. 22, 1903 | 6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Iowa | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD | | |
| 10. CITY OR TOWN OF DEATH: Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Architect | 12b. KIND OF BUSINESS OR INDUSTRY: Self-employed | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Florida | Palm Beach | Delray Beach | YES [X] NO [ ] | 342 Southwest First Avenue 33444 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Nils | | Jacobson | Augusta | | Olson |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 262-34-1504 | Josephine J. Hoge, | 7314 Holly Avenue Takoma Park, MD 20912 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CARDIAC ARREST | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | DEMENTIA | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 12/12, 19 88, to 12/19, 19 88, that (I) (we) last saw the deceased alive on 12/12, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| K Sudhakar | ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 12/19/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| K. SUDHAKAR, MD | 7610 CARROLL AVE #230 TAKOMA PARK, MD 20912 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | 12-20-88 | Suburban Crematory | Silver Spring, Maryland |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 | DEC 22 1988 | Julia Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 10 60M 7-84
(VRA 15, 4)

D19351 JAN 17 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 37119

1. DECEASED NAME (TYPE OR PRINT): First Lawrence; Middle J.; Last Jaffe
2a. DATE OF DEATH: Month December; Day 24; Year 1988
2b. HOUR: 4p. M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: Month June; Day 20; Year 1929
6. AGE (IN YEARS LAST BIRTHDAY): 59 YRS
If under 1 year: Months; Days
If under 24 hrs.: Hours; Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.
7b. CITIZEN OF WHAT COUNTRY?: U.S.A
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Bethesda
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 5116 Moorland Lane
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Self Employed
12b. KIND OF BUSINESS OR INDUSTRY: General Contractor

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Bethesda
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS: 5116 Moorland Lane 20814

14. FATHER'S NAME: First Harry; Middle; Last Jaffe
15. MOTHER'S MAIDEN NAME: First Lillian; Middle; Last Raffleman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 579-34-5428
17. INFORMANT: Michele Jaffe
ADDRESS: 5116 Moorland Lane, Bethesda, MD. 20814

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Salivary Gland Carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 1/2 years
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2):
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):
21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from Sept. 3, 19 87, to Dec. 24, 19 88, that (I) (we) last saw the deceased alive on Dec. 22, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: Dec. 27, 1988
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Phillip Cohen
22e. ADDRESS: 22 nd & I Streets N.W., Washington, D.C.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation
23b. DATE: 12-27-88
23c. NAME OF CEMETERY OR CREMATORY: Mt. Comfort
23d. LOCATION: CITY OR TOWN; COUNTY; STATE: Alexandria, Virginia
24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons
ADDRESS: 5130 Wisconsin Ave. N.W. Washington, D.C. 20016
25a. DATE REC'D. BY REGISTRAR: DEC 28 '88
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The clerk will remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 80

DHMH - 16 50M 1/81 (VRA 15, 4)

016495 DEC 16 88

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 37120
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| VIOLA | AGNES | JENKINS | DECEMBER 12, 1988 | 9:24 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | DECEMBER 21, 1913 | 74 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| | USA | | MONTGOMERY COUNTY, MD MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| BETHESDA | NIH, THE CLINICAL CENTER | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| WEST VIRGINIA | | KEYSER | YES ☐ NO ☐ | T#2, SILVER TREE #102 / 26726 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| ALBERT | | MARTIN | MARTHA | | SIMPSON |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 218-22-5530 | ROBERT JENKINS | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Septic Shock | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | peritonitis | unknown |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 11/29/88 | Prosthetic mitral valve dysfunction | YES ☒ NO ☐ | YES ☒ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that ☒ (this hospital) attended the deceased from October 6, 19 88, to December 12, 19 88, that ☒ (we) last saw the deceased alive on December 12, 19 88, and that in (☒) (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (we) (did) ~~did not~~ view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Julie Swain MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/13/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Julie SWAIN | National INstitutes of Health 9000 Rockville PIke, Bethesda, Maryland 20892 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| BURIAL | 11-15-88 | OAK LAWN | BALTO | | MD. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| JOHN M. WEBER & SONS | 401 S CHESTER ST | DEC 15 1988 | Julia Davidson-Rondeau |

BP

DHMH 16 60M 7/84 (VRA 16, 4)

016407 DEC 15 88

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR — REG. NO. 7121

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Gordon | MIDDLE: Rickus | LAST: Johnstone | 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH DAY YEAR: 12/12 19 88 | 2b. HOUR: M | | | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Aug. 7, 1925 | 6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS. | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 12/12 19 88 | 2d. HOUR: 7:40 A. M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Illinois | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD | | | | |
| 10. CITY OR TOWN OF DEATH: Olney | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 3226 Spartan Road, #55 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Office worker | 12b. KIND OF BUSINESS OR INDUSTRY: Drug Store | | | | |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Olney | YES [X] NO [ ] | 3226 Spartan Road, #55 20832 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | |
|---|---|---|
| Harry / / Johnstone | Hulda / Mae / Dunton | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): N/A (IF YES, GIVE WAR OR DATES): N/A | 16b. SOCIAL SECURITY NO.: 227-20-3515 | 17. INFORMANT (sister) ADDRESS: Lesla J. Cullifer 1262 14th. St. Imperial Beach, CA 92032 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute myocardial disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): chronic myocardial disease.

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a: None

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| None | | YES [ ] NO [X] |

| 21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): None |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: John S. Rogers M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 12/12/88

EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers, M.D. ADDRESS: 1919 Seminary Road Silver Spring, Montgomery County, MD

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | 12-13-1988 | Metropolitan Crematory | Alexandria / / Virginia |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Hines/Rinaldi Funeral Home 11800 N.H. Ave., Sil. Spr. Md. | DEC 13 1988 | Julia Dendon-Randall |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

019653 JAN 18 88 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37122 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | Augusta F. Jones | | 2a. DATE OF DEATH MONTH DAY YEAR | 12-22-88 | 2b. HOUR 1650 M |
| 3. SEX | FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR | NOV. 26, 1906 | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. |
| 10. CITY OR TOWN OF DEATH | Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | SHADY GROVE ADVENTIST HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Secretary |
| | | | | 12b. KIND OF BUSINESS OR INDUSTRY | Unknown |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD. | BALTIMORE | BALTIMORE | YES ☒ NO ☐ | 627-DUNKIRK ROAD, 21212 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| WILLIAM JOYCE | ANNIE HOLT |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| NO | | 215-09-9913 | REV. DR. REICHARD- NLH-ROCKVILLE, MD. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CLINICAL C.V.A — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ACUTE

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ XX | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (~~this hospital~~) attended the deceased from NOV 88 to DEC 22 19 66, that (I) (~~we~~) last saw the deceased alive on DEC 22 19 88 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
|---|---|---|---|
| Thomas E. Dooley | MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | DEC 23, 1988 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Thomas E. Dooley MD | 17904 GEORGIA AVENUE OLNEY, MARYLAND 20832 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | DEC. 27, 1988 | WOODLAWN CEM. | BALTIMORE, MARYLAND |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HYSONG CO., INC.-1300-N ST., NW WASH., DC | JAN 13 1989 | |

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

18351 JAN -6 89

1 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

88 37123
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: George | Middle: W | Last: Jones | 2a. DATE OF DEATH Month Day Year: 12 22 88 | 2b. HOUR: 1155 M | |
| 3. SEX: M | 4. RACE: NEGRO | 5. DATE OF BIRTH Month Day Year: March 26, 1917 | 6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NORTH CAROLINA | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH: TAKOMA PARK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST HOSPT. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CUSTODIAN | 12b. KIND OF BUSINESS OR INDUSTRY: M.C.P.S. | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MARYLAND | MONTGOMERY | TAKOMA | YES [X] NO [ ] | 6735 New Hampshire Ave. Apt. 404-E |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last | |
|---|---|---|
| MILTON JONES | FANNIE WATSON | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| YES | WWII | 238-12-9112 | ELLA M. JONES-WIFE | 6735 New Hampshire Ave. Takoma Park, Md. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Respiratory Failure, Acute Collapse | 2 Minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Sepsis | 3 Days |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Lung Cancer | 1 year |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Chronic Obstructive Lung Disease, Diabetes Mellitus

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 11-22, 19 88, to 12-22, 19 88, that (I) (we) last saw the deceased alive on 12-22, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | 22c. DATE SIGNED |
|---|---|---|---|---|
| [signature] | M.D. | ATTENDING PHYSICIAN [X] | MEDICAL DIRECTOR [ ] | STAFF PHYSICIAN [ ] | 12/23/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| OKi KWON, M.D. | 8580 Selkirk Ave. Silver Spring MD 20910 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 12/29/88 | QUANTICO NATIONAL | TRIANGLE, VIRGINIA |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| MORROW & WOODFORD, INC. 1622 11TH. ST., N.W. WASH., DC 20001 | DEC 30 1988 | Julia Davidson-Randall |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

016233 DEC 15 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37124 REG. NO

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| MURRAY | E. | KAMRASS | 11-25-88 | 2354 M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Male | Caucasian | January 24, 1921 | 67 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| New York | United States | | Montgomery Co. MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Bethesda | Suburban Hospital | Operations Research Analyst | Institute for Defense Analyse |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Bethesda | YES ☐ NO ☒ | 5311 Waneta Road/ 20816 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Daniel | | Kamrass | Anna | | Massin |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WW II | 051-16-6663 | Geraldine A. Kamrass | Wife same as #13 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | carcinomatosis | > mos. |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO, OR AS A CONSEQUENCE OF (b) | metastatic rib + spine disease | 5 mos. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | carcinoma of prostate | 2 yrs. |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
cerebral thrombosis

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (~~the hospital~~) attended the deceased from July 1963 to Nov 1988, that (I) (we) last saw the deceased alive on 11/25 1988, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we did~~) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|---|
| Marvin Wadler | M.D. | | 11/25/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| MARVIN WADLER | 8218 Wisconsin Av, Bethesda Md. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | November 25, 1988 | Montgomery Crematorium, Inc. | Bethesda/Montgomery/Maryland |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814 | NOV 29 1988 | Gina Lundeen Landau |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

016234 DEC 15 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 37125

FOR STATE REGISTRAR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: MILTON; MIDDLE: ; LAST: KAPLAN | 2. SEX: male | 3. RACE: WHITE | 4. DATE OF BIRTH MONTH DAY YEAR: 10 10 13 | 5. AGE (IN YEARS LAST BIRTHDAY): 70 YRS | 6a. DATE OF DEATH MONTH DAY YEAR: NOV 24 88 |
| 6b. HOUR: 1215 AM | IF UNDER 1 YEAR MONTHS / DAYS: | IF UNDER 24 HRS HOURS / MIN.: | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. | 8. MARRIED ☐ NEVER MARRIED ☒ XX WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH: TAKOMA PARK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): LIBRARIAN | 12b. KIND OF BUSINESS OR INDUSTRY: US GOVERNMENT | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
|---|---|---|---|---|---|
| MARYLAND | PR. GEORGES | CHILLUM TERRACE | YES ☒ NO ☐ | 843 COX AVENUE | 20783 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | |
|---|---|---|
| EDWIN I. KAPLAN | REBA S. MOREWITZ | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 137-14-2182A | 17. INFORMANT ADDRESS: DORIS D. KAPLAN, 11613 MILBERN DRIVE POTOMAC, MARYLAND |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiopulmonary Arrest | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Hypovolemia, Anemia, Septic Shock | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Atelectasis Lung | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Carcinoma. Gen c Metastasis

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|

22a. I certify that (I) (this hospital) attended the deceased from 11/24, 19 88, to 11/24, 19 88, that (I) (we) last saw the deceased alive on ____, 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|
| [signature] | | 11/24/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| VIVEK CHAID M.D | 3311 Toledo Terr HYATTSVILLE, MARYLAND |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 11/25/1988 | HEBREW CEMETERY | HAMPTON VIRGINIA |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR SIGNATURE |
|---|---|---|
| DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C. | NOV 29 1988 | [signature] |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP____

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 37126 REG. NO.

0166790 DEC 20 '88

1 - FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT): First: Janet; Middle: Ellen; Last: Katz

2a. DATE OF DEATH: December 15, 1988

2b. HOUR: 10:58 P M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: November 10, 1920

6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 2201 Colston Drive, #803

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Silver Spring

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: #803 2201 Colston Drive / 20910

14. FATHER'S NAME: First: Morton; Middle: P.; Last: Eichenberg

15. MOTHER'S MAIDEN NAME: First: Olga; Middle: ; Last: Kling

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 077-16-6363

17. INFORMANT: Bruce J. Steinhardt, ADDRESS: 7725 Rocton Avenue Chevy Chase, MD 20815

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Emphysema
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: year

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Ca Pulmonis

19a. DATE OF OPERATION: None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec 84, to December 15, 1988, that (I) (we) last saw the deceased alive on Dec 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Joel R. Schulman, M.D. DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: Dec. 16, 1988

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Joel R. Schulman, M. D.

22e. ADDRESS: 9401 Old Georgetown Road Bethesda, MD 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 12-16-88

23c. NAME OF CEMETERY OR CREMATORY: Baltimore-Washington Crem.

23d. LOCATION CITY OR TOWN: Laurel COUNTY: Maryland STATE:

24. FUNERAL DIRECTOR NAME AND ADDRESS: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

25a. DATE REC'D BY REGISTRAR: DEC 19 1988

25b. REGISTRAR'S SIGNATURE: Barbara Ramsey

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes," the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

19032 JAN 13 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

88 37127 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) First: Thelma Middle: A. Last: Kennedy

2a. DATE OF DEATH Month: 12 Day: 26 Year: 88

2b. HOUR: 8 P.M

3. SEX: FEMALE

4. RACE: CAUCASIAN

5. DATE OF BIRTH Month: OCT Day: 4 Year: 1906

6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: SILVER SPRING

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MERIDIAN NURSING HOME

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: MONTGOMERY

13c. CITY OR TOWN: SILVER SPRING

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: 15042 HASLEMERE COURT 20906

14. FATHER'S NAME First: WILLIAM Middle: CLINTON Last: ALLARD

15. MOTHER'S MAIDEN NAME First: ELIZABETH Middle: C. Last: HANSON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 577-07-0568

17. INFORMANT: SON RAYMOND KENNEDY ADDRESS: 3104 SEDGWICK LANE BOWIE, MD 20715

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Severe Dehydration Malnutrition
DUE TO, OR AS A CONSEQUENCE OF (c): Generalized Carcinomatosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/08/88 to 12/26/88, that (I) (we) last saw the deceased alive on 12/26/88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: S K Gupta DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12/26/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): SK GUPTA

22e. ADDRESS: 9801 GEORGIA AVE #2-20 SILVER SPRING, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: DEC 28, 1988

23c. NAME OF CEMETERY OR CREMATORY: PROSPECT HILL CEMETERY

23d. LOCATION CITY OR TOWN: WASHINGTON, DC COUNTY STATE

24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901

25a. DATE REC'D. BY REGISTRAR: DEC 27 '88

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP 20

DHMH - 16 60M 7/84
(VRA 15, 4)

016683 DEC 2 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 37128

| 1. DECEASED NAME (TYPE OR PRINT) | FIRST | MIDDLE | LAST |
|---|---|---|---|
| | PAUL | P | KERN |

2a. DATE OF DEATH: MONTH 12 DAY 13 YEAR 88 — 2b. HOUR 0238 AM

3. SEX: Male — 4. RACE: CAUC — 5. DATE OF BIRTH: MONTH / DAY 05 YEAR 26 — 6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash.,D.C. — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.

10. CITY OR TOWN OF DEATH: Takoma Park — 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ComputerAnalyst; — 12b. KIND OF BUSINESS OR INDUSTRY: U.S.Gov.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Montgomery — 13c. CITY OR TOWN: Silver Spring — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 2700 Barker Drive (20910)

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Morris | | Kern | Elizabeth | | Lean |

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): Korean — 16b. SOCIAL SECURITY NO.: 578-24-8170 — 17. INFORMANT ADDRESS: Kensington, Md. 20895: Miriam Larkin;Sister;2710 Jennings Rd.;

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIAC ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b): SEPSIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c): CHRONIC RENAL FAILURE

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): DIABETES MELLITUS

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/12 19 88 to 12/13 19 88, that (I) (we) last saw the deceased alive on 12/12 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/13/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): K. SUDHAKAR, MD — 22e. ADDRESS: 7610 CARROLL AVENUE #230 TAKOMA PARK, MD 20912

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12/18/88 | King David Mem.Garden | Falls Church;Fairfax;Va. |

24. FUNERAL DIRECTOR NAME: DANZANSKY-GOLDBERG MEMORIAL CHAPELS — ADDRESS: 1170 Rockville Pike; Rockville, Md. 20852 — DATE RECD. BY REGISTRAR: DEC 19 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

016552 DEC 1 '88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO 88 37129

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST Flora MIDDLE Clinton LAST Kile | | | | 2a. DATE OF DEATH MONTH 12 DAY 4 YEAR 88 | 2b. HOUR 1235 A.M. |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH Nov. DAY 23, YEAR 1890 | 6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IN | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH Wheaton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills N. H. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | 12b. KIND OF BUSINESS OR INDUSTRY I.R.S. | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | Mont. | Bethesda | YES ☒ NO ☐ | 6508 Wiscassett Rd. 20816 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Henry | | Clinton | Martha | | Flinn |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 578-46-1108 | Ronald C. Lile 602 Dreams Landing Way | Annapolis, MD 21401 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) PNEUMONIA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 WEEK

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) chronic obstructive lung disease — years

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): arteriosclerotic cardiovascular disease

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 2/16, 1982, to 12/4 1988, that (I) (we) last saw the deceased alive on 12/4 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE / DEGREE | ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN | 22c. DATE SIGNED |
|---|---|---|
| B.N. Rosenbaum, M.D. | ☐ ☒ ☐ | 12/4/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| B.N. ROSENBAUM | 3720 FARRAGUT AVE. KENSINGTON, MD. 20895 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12/8/88 | Ft. Lincoln Cem. | Brentwood, MD |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Joseph Gawler's Sons, Inc. | 5130 WI Ave. NW Wash., DC 20016 | DEC 7 '88 | Lydia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

018149 JAN -5 89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

58 37130
REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Robert | Middle: Reginald | Last: Kilgo | 2a. DATE OF DEATH Month/Day/Year: 12 30 88 | 2b. HOUR: 1330 P M | |
| 3. SEX: Male | 4. RACE: Black | 5. DATE OF BIRTH Month/Day/Year: August 30, 1925 | 6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH: Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Desk Clerk | 12b. KIND OF BUSINESS OR INDUSTRY: Apartment | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Rockville | YES [X] NO [ ] | 600 Douglass Ave., 20850 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last |
|---|---|
| William Reginald Dean | Eloise Simms |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| Yes | WW II | 219-14-9200 | Maude S. Kilgo, 600 Douglass Ave, Rockville, Md. |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiorespiratory Arrest.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Cancer of pancreas

DUE TO, OR AS A CONSEQUENCE OF (c): Secondary Biliary Obstruction

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [ ] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from Spring 88, to Present 19____, that (I) (we) last saw the deceased alive on 12/30 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I)(we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| D Shumaker, MD | ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] | 12/31/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DOUGLAS R. SHUMAKER, MD | 615 W. MONT. AVE. ROCKVILLE MD 20850 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | 12/31/88 | J. William Lee's Sons | Washington, D.C. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| McGuire Funeral Serv. | 7400 Georgia Ave. N.W. Washington, D.C. | JAN 3 1989 | Julia Davidson-Trundell |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

017026 DEC 22 88

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37131
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | CHANG DUK KIM | 2a. DATE OF DEATH MONTH DAY YEAR | DEC. 18 1988 | 2b. HOUR | 6:15P M |
| 3. SEX | MALE | 4. RACE | Korean | 5. DATE OF BIRTH MONTH DAY YEAR | Nov. 21, 1921 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 67 YRS | IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS. HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Korea | 7b. CITIZEN OF WHAT COUNTRY? | Resident | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH | Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Suburban Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Cleaners |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Md. | 13b. COUNTY | Mont. | 13c. CITY OR TOWN | Rockville |
| 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | | 13e. STREET ADDRESS | 12602 Viers Mill Rd. 20853 | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | Unobtainable | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Unobtainable | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | N/A | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | 229 31 6760 |
| 17. INFORMANT | Ilam Kim (Son) | ADDRESS | Same as 13E | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Large Cell Carcinoma of Lung | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Metastatic Carcinomas of Mediastinum | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Peritoneum & Kidneys Bronchopneumonia | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Anemia, Cachexia, Hypoxemia

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/21 19 88 to Dec 17 19 88, that (I) (we) last saw the deceased alive on Dec 17 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED 12/19/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Yoo 22e. ADDRESS 1140 Varnum St.N.E.

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Burial | 23b. DATE | 12/20/88 | 23c. NAME OF CEMETERY OR CREMATORY: George Washington |
| 23d. LOCATION CITY OR TOWN | Adelphi | COUNTY | PG | STATE Md. |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md. | 25a. DATE REC'D. BY REGISTRAR | DEC 20 1988 | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall |

015566 DEC-7 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37132
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: WON | MIDDLE: GOO | LAST: KIM | 2a. DATE OF DEATH MONTH: DEC. | DAY: 4 | YEAR: 1988 |
| 2b. HOUR: 1:22 P M | | | | | |
| 3. SEX: Male | 4. RACE: Korean | 5. DATE OF BIRTH MONTH: May | DAY: 29 | YEAR: 1942 | 6. AGE (IN YEARS LAST BIRTHDAY): 46 YRS |
| IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 2 HRS: HOURS / MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): KOrea | 7b. CITIZEN OF WHAT COUNTRY?: Permanent resident | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH: Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Pastor | 12b. KIND OF BUSINESS OR INDUSTRY: Church | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Silver Spring | YES [X] NO [ ] | 2001 Mayflower Drive 20904 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Jung | Suk | Kim | Won | Nam | Lee |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| N/A | N/A | 413-98-7567 | Moon Ja Kim - wife- | (same as 13e) |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours.

DUE TO, OR AS A CONSEQUENCE OF

(b) TERMINAL METASTATIC ADENOCARCINOMA OF STOMACH MONTHS.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: massive metastic hepatomegaly, severe anemia with recurrent G.I. bleeding

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| [ ] | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from Nov.10, 1988, to Dec. 4, 1988, that (I) (we) last saw the deceased alive on Dec.4, 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Peter W. Yim | M.D. ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | DEC.4 1988 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Peter W. Yim, MD | 7900 Old Branch Ave., Clinton, Md. 20735 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec. 6, 1988 | Norbeck Mem. Park | Olney Montgomery Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Hines/Rinaldi Funeral Home | 11800 N.H. Ave., Sil. Spr. Md. | DEC 6 - 1988 | Gerdson Randall |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 037133

19031 JAN 13 19

1. DECEASED NAME (TYPE OR PRINT): FIRST THOMAS MIDDLE B LAST KINDER, Sr
2a. DATE OF DEATH: MONTH 12 DAY 24 YEAR 88
2b. HOUR: 1:29 AM
3. SEX: Male
4. RACE: Caucasian
5. DATE OF BIRTH: MONTH Nov. DAY 12, YEAR 1912
6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: United States
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: Bethesda.
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SuburBAN HOSPITAL.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Bricklayer
12b. KIND OF BUSINESS OR INDUSTRY: Building Contractor

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: ROckville
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS: 339 Seth Place 20850

14. FATHER'S NAME: FIRST Harvey MIDDLE Brooks LAST Kinder
15. MOTHER'S MAIDEN NAME: FIRST Not MIDDLE Available LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 715 03 6702
17. INFORMANT ADDRESS: Pauline V. Kinder wife same as item 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Sepsis
DUE TO, OR AS A CONSEQUENCE OF (c): squamous cell cancer
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/23 19 84, to 12/24 19 88, that (I) (we) last saw the deceased alive on 12/23 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Frauke Westphal M.D. DEGREE
ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: Dec 24, 1988
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Frauke Westphal, M.D.
22e. ADDRESS: 809 Viers Mill Road Rockville, Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Dec. 28, 1988
23c. NAME OF CEMETERY OR CREMATORY: Rockville Cemetery
23d. LOCATION CITY OR TOWN: Rockville COUNTY: Maryland STATE:

24. FUNERAL DIRECTOR NAME: Robert A. Pumphrey Funeral Home
Rockville Inc. 300 West Montgomery Ave.
Rockville, Maryland 20850
25a. DATE REC'D. BY REGISTRAR: DEC 28'88
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

015347 DEC-8

88 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

33 37134 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: ELEANOR | MIDDLE | LAST: KLEIN | 2a. DATE OF DEATH MONTH: 12 | DAY: 02 | YEAR: 88 |
| 2b. HOUR: 4A. M | | | | | |
| 3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH: 4 DAY: 9 YEAR: 08 | 6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH: Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Hebrew Home of Greater Wash. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Legal Secretary | 12b. KIND OF BUSINESS OR INDUSTRY: Law Offic | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Virginia | Fairfax | Reston | YES ☐ NO ☐ | 11450 North Shore Drive |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | |
|---|---|---|
| Hyman / Rosen | Lena / Berkowitz | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 074-24-4606 | Richard Klein | 1607 Sadlers Wells Dr. Herndon, Virginia |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): SEPTICEMIC SHOCK — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 WEEK

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): BILATERAL PNEUMONITIS

DUE TO, OR AS A CONSEQUENCE OF (c): RECURRENT ASPIRATION

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): PRIMARY DEMENTIA, DEGENERATIVE

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 10/9/86 to 12/2/88, that (I) (we) last saw the deceased alive on 12/2/88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: M.D. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ — 22c. DATE SIGNED: 12/2/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): D. D. PATEL — 22e. ADDRESS: 6121 MONTROSE RD ROCKVILLE MD

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12-4-88 | KING DAVID | Falls Church, Va. |

24. FUNERAL DIRECTOR NAME / ADDRESS: Ives-Pearson Funeral Homes, 2847 Wilson Blvd. Arlington, Va.

25a. DATE REC'D BY REGISTRAR: DEC 5 - 1988 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP

DHMH-16 509A 1/81 (VRA 15, 4)

018455 JAN -9 89

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37135
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1a. DECEASED NAME (TYPE OR PRINT) — FIRST: Loretta — MIDDLE: F. — LAST: Klodzen

2a. DATE OF DEATH — MONTH DAY YEAR: December 18, 1988 — 2b. HOUR: 9:56p M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH DAY YEAR: Mar. 6, 1898

6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash., DC

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Takoma Park

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wash. Adv. Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Wash., DC — 13b. COUNTY: N/A — 13c. CITY OR TOWN: Wash. — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 5415 CT Ave. NW 20015

14. FATHER'S NAME — FIRST: Joseph — MIDDLE — LAST: Shanley

15. MOTHER'S MAIDEN NAME — FIRST: Bridget — MIDDLE — LAST: Donnelly

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 579-60-9639

17. INFORMANT — ADDRESS: Marie K. Sabin — 15209 Rosecroft Rd. Rockville, MD 20853

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Immediate

DUE TO, OR AS A CONSEQUENCE OF (b): Organic Heart Disease — 10 years

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 10-31-83, 19____, to 12-18, 19 88, that (I) (we) last saw the deceased alive on 12-15, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Jon M Wiseman — DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12-19-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Jon M. Wiseman, M.D.

22e. ADDRESS: 5410 CT. Ave.N.W., Washington, D.C. 20015

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 12/22/88

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem

23d. LOCATION — CITY OR TOWN: Silver Spring, — COUNTY: MD — STATE

24. FUNERAL DIRECTOR — NAME: Joseph Gawler's Sons, Inc. — ADDRESS: 5130 WI Ave. NW Wash., DC 20016

25a. DATE REC'D. BY REGISTRAR: DEC 21 88

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-1650M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 37136

0184541 JAN -5

1. DECEASED NAME (TYPE OR PRINT): FIRST KATHARINA MIDDLE ROTH LAST KNECHTEL
2a. DATE OF DEATH: MONTH Dec DAY 21 YEAR 88
2b. HOUR 7:30 Pm
3. SEX: FEMALE
4. RACE: CAUCASIAN
5. DATE OF BIRTH: MONTH JUNE DAY 16 YEAR 1894
6. AGE (IN YEARS LAST BIRTHDAY): 94 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): AUSTRIA
7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.
10. CITY OR TOWN OF DEATH: Bethesda
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): GROSVENOR HEALTH CARE CENTER
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): DRESSMAKER
12b. KIND OF BUSINESS OR INDUSTRY: SELF-EMPLOYED

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY: MONTGOMERY
13c. CITY OR TOWN: POTOMAC
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS / ZIP CODE: 11004 HOMEPLACE LANE, 20854

14. FATHER'S NAME: FIRST JOHANN MIDDLE LAST ROTH
15. MOTHER'S MAIDEN NAME: FIRST MIDDLE LAST NOT AVAILABLE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 578-46-7823
17. INFORMANT ADDRESS: POTOMAC, MARYLAND — JOAN E. HEKIMIAN, 11004 HOMEPLACE LANE, 20854

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Bile Duct Carcinoma.
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 7-20, 19 87, to 12-21, 19 88, that (I) (was) last saw the deceased alive on 12-20, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.

22b. SIGNATURE: John Tauber — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12-21-88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): John Tauber
22e. ADDRESS: 8218 WISCONSIN Ave, Bethesda, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION
23b. DATE: DECEMBER 22, 1988
23c. NAME OF CEMETERY OR CREMATORY: MONTGOMERY CREMATORIUM, INC.
23d. LOCATION: CITY OR TOWN BETHESDA, COUNTY MONTGOMERY, STATE MARYLAND
24. FUNERAL DIRECTOR NAME: ROBERT A. PUMPHREY FUNERAL HOME, ROCKVILLE, INC. ADDRESS: 300 W. MONTGOMERY AVENUE, ROCKVILLE, MARYLAND 20850
25. DATE RECEIVED BY REGISTRAR: 1-5-89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified or the case referred by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DHMH - 16 60M 7/84
(VRA 15, 4)

016211 DEC 1988

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

83 37137
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Augusta | MIDDLE | LAST: Kramer | 2a. DATE OF DEATH MONTH DAY YEAR: December 2, 1988 |
| 2b. HOUR: 10 00 AM | | | |
| 3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: 6 25 1898 | 6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS |
| IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD |
| 10. CITY OR TOWN OF DEATH: Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Montgomery | Rockville | YES ☒ NO ☐ | 6111 Montrose Road, #905 20852 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Morris Ladenheim | Toni Herman |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | N/A | 075-28-9442 | Charles Ladenheim | 7508 Radnor Road Bethesda, Md. 20817 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Renal failure. | 0/mon. 10 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Congestive heart failure | years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Arteriosclerotic heart disease. | years |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

Acute myocardial infarction, atrial fibrillation, chronic

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 7-6- 19 88, to 12-2 19 88, that (I) (we) last saw the deceased alive on 12-2- 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN | 22c. DATE SIGNED |
|---|---|---|---|
| Joseph A. Romeo | MD | ☐ ☒ ☐ | 12 2 88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| JOSEPH A. ROMEO MD | 10401 old Georgetown Rd. Bethesda, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | 12/3/88 | Metropolitan Crematory | Alexandria, Va. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Ives-Pearson Funeral Home 2847 Wilson Blvd., Arlington, Va. 22201 | DEC 6 1988 | |

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

016678 DEC 2088

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

88 37133 REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) | FIRST | MIDDLE | LAST |
|---|---|---|---|
| | Helen HELEN | Steele | Kriger KRIGER |

| 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
|---|---|---|---|---|
| | 12 | 15 | 88 | 9:37 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH (MONTH DAY YEAR) | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| Female | caucasian | July 24, 1908 | 80 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 | 9 BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Canada | United States | MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | Montgomery County MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Silver Spring | 3232 Gleneagles Drive | Homemaker | Own Home |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Montgomery | Silver Spring | YES ☐ NO ☒ | 3232 Gleneagles Drive / 20906 |

| 14. FATHER'S NAME (FIRST MIDDLE LAST) | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) |
|---|---|
| Philip Arthur Steele | Amelia Schmidt Leclaire |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 213-40-8338 | Lucy B. Logan, | 2319 East Victory Drive Tempe, AZ 85281 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardio Respiratory Failure. | Immediate |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Adeno Carcinoma of Pleura Bilat | 7 months |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☑ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (~~this hospital~~) attended the deceased from 1985, 19____, to 12/15, 19 88 that (I) (we) last saw the deceased alive on 12/14 19 88, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Oliver J. Lawless MD | ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/15/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| OLIVER J. LAWLESS | 3801 International Drive Silver Spring |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12-17-88 | Prospect Hill Cemetery | Front Royal, Virginia |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Rapp Funeral Services, P. A. | 933 Gist Avenue, Silver Spring, MD 20910 | DEC 19 1988 | Linda Davidson-Kondalow |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 16 60M 7/84 (VRA 15, 4)

017717 DEC 30 1988

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37139
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: ANNA; MIDDLE: ; LAST: KURSTIN | | | 2a. DATE OF DEATH MONTH 12 DAY 24 YEAR 88 | 2b. HOUR 4:45 AM | |
| 3. SEX: female | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH 8 DAY 15 1892 | 6. AGE (IN YEARS LAST BIRTHDAY): 96 YRS | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Lithunia | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONT. Rockville MD. | | |
| 10. CITY OR TOWN OF DEATH: Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): GREATER WASHINGTON Hebrew Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: HOMEMAKER | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD | 13b. COUNTY | 13c. CITY OR TOWN: SILVER SPRING | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 14508 HOMECREST RD. #20906 | |
| 14. FATHER'S NAME FIRST: JACOB; MIDDLE: ; LAST: HARRIS | | | 15. MOTHER'S MAIDEN NAME FIRST: TOBA; MIDDLE: ; LAST: UNKNOWN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 579-66-0314 | 17. INFORMANT ADDRESS: DR. WILLIAM KURSTIN 2912 ELLICOTT TERRACE WASHINGTON, D.C. 20008 N.W. | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: seconds
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Congestive Heart Failure — minutes
DUE TO, OR AS A CONSEQUENCE OF (c): Cardiomopathy — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 10-26, 19 88, to 12-24, 19 88, that (I) (we) last saw the deceased alive on 12-23, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12-24-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Daniel R Jaller — 22e. ADDRESS: HEBREW HOME OF GREATER WASHINGTON ROCKVILLE, MD.

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: 12/26/88 | 23c. NAME OF CEMETERY OR CREMATORY: HEBREW YOUNG MENS | 23d. LOCATION CITY OR TOWN: WOODLAWN, COUNTY: BALTO., STATE: MD. | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215) | 25a. DATE REC'D. BY REGISTRAR: DEC 29 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 37140

016562 DEC 19 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be omitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the case.

| | | | | | |
|---|---|---|---|---|---|
| 1a. DECEASED NAME (TYPE OR PRINT) FIRST | HILDA | MIDDLE | KUSHNER | LAST | |
| 2a. DATE OF DEATH MONTH DAY YEAR | DECEMBER 12 1988 | | 2b. HOUR | 5:22 PM | |
| 3. SEX | FEMALE | 4. RACE | WHITE | | |
| 5. DATE OF BIRTH MONTH DAY YEAR | JANUARY 16, 1909 | 6. AGE (IN YEARS LAST BIRTHDAY) | 79 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? | U. S. A. | | |
| 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | | 9. BALTIMORE CITY OR COUNTY OF DEATH | MONTGOMERY COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH | SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | HOLY CROSS HOSPITAL | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE) | ADMINISTRATIVE ASSISTANT | 12b. KIND OF BUSINESS OR INDUSTRY | DEPARTMENT OF STATE | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | DISTRICT OF COLUMBIA | 13b. COUNTY | none | 13c. CITY OR TOWN | WASHINGTON |
| 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | | 13e. STREET ADDRESS | 7439 9th STREET, N. W. | 20012 | |
| 14. FATHER'S NAME FIRST | LOUIS | MIDDLE | H. | LAST | KUSHNER |
| 15. MOTHER'S MAIDEN NAME FIRST | ROSE | MIDDLE | MILDRED | LAST | TOCKER |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | NO | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | 578-22-9132 |
| 17. INFORMANT | LOUIS H. DIAMOND, | ADDRESS | 8000 BRAEBURN PARKWAY, BETHESDA, MARYLAND | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial Infarct — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 hour

DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis — 20 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Chronic Renal Failure

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from Dec 85 to Dec 12 19 88, that (I) (we) last saw the deceased alive on Dec 12 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | S. Hellman | DEGREE MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ |
| 22c. DATE SIGNED | 12/13/88 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | Stephen Hellman | 22e. ADDRESS | 6240 MOUTROSE Rd Rockville, Md |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | BURIAL | 23b. DATE | 12/14/1988 | 23c. NAME OF CEMETERY OR CREMATORY: KING DAVID MEMORIAL GARDEN |
| 23d. LOCATION CITY OR TOWN / COUNTY / STATE | FALLS CHURCH, VIRGINIA | | | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C. | 25a. DATE REC'D. BY REGISTRAR | DEC 16 1988 | 25b. REGISTRAR'S SIGNATURE |

BP

DHMH- 16 50M 1/81 (VRA 15, 4)

017578 DEC 30

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 037141

1. DECEASED NAME (TYPE OR PRINT): FIRST Emily MIDDLE M. LAST Lamborn — EMILY M. LAMBORN
2a. DATE OF DEATH: MONTH DAY YEAR 12-6-88
2b. HOUR 4:20 PM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: MONTH DAY YEAR Apr. 30, 1910
6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY Co. MD.
10. CITY OR TOWN OF DEATH: BETHESDA
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SUBURBAN HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Deputy Commissioner
12b. KIND OF BUSINESS OR INDUSTRY: HEW

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: ---
13b. COUNTY: ---
13c. CITY OR TOWN: Washington, DC
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 3750 Jocelyn Street, N.W. 20015

14. FATHER'S NAME: FIRST Rossel MIDDLE -- LAST Mitchell
15. MOTHER'S MAIDEN NAME: FIRST Emily MIDDLE -- LAST McDowell
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES): ---
16b. SOCIAL SECURITY NO.: 579-58-0526
17. INFORMANT ADDRESS: Alyne L. Ellis, Same address as #13.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Obstructive Pulmonary Dis — 4 yrs
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from June 19 1970 to 12-6 19 88, that (I) (we) last saw the deceased alive on 12-6 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: Albert Luckett MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12-8-88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): (Mr.) F. Luckett
22e. ADDRESS: 5000 Reno Rd NW 20008

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation
23b. DATE: 12/8/88
23c. NAME OF CEMETERY OR CREMATORY: Mt. Comfort Crematory
23d. LOCATION CITY OR TOWN: Alexandria COUNTY: VA STATE:
24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons, Inc. ADDRESS: 5130 Wisconsin Ave, NW, Washington, D.C. 20016
25a. DATE REC'D. BY REGISTRAR: DEC 9 '88
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 1650M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 3 7 1 4 5

HELEN M. LAMBRAKIS

0182788 JAN

1. DECEASED NAME (TYPE OR PRINT): FIRST Helen MIDDLE M. LAST LAMBRAKIS
2a. DATE OF DEATH: MONTH 1 DAY 1 YEAR 89
2b. HOUR 10 15 M
3. SEX: Female.
4. RACE: White.
5. DATE OF BIRTH: MONTH APRIL DAY 20 YEAR 1898
6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): GREECE
7b. CITIZEN OF WHAT COUNTRY?: U.S.A
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: Bethesda.
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Grosvenor Health Care Center.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY MONT. 13c. CITY OR TOWN TAKOMA PARK 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS 8015 MAPLE AVENUE 20912

14. FATHER'S NAME: FIRST NOT MIDDLE AVAILABLE LAST
15. MOTHER'S MAIDEN NAME: FIRST NOT MIDDLE AVAILABLE LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 555-46-1477
17. INFORMANT: DEBORAH LUXENBERG ADDRESS: 806 15th ST NW DC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Respiratory arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Arterio Sclerosis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
Transient Ischemic attacks.

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 5-25, 1988, to 1-1, 1989, that (I) (~~was~~) last saw the deceased alive on 12-19, 1988, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~was~~) (did) (~~did not~~) view the body after death.
22b. SIGNATURE: John Tauber DEGREE: MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 1-1-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): John Tauber
22e. ADDRESS: 8218 Wisconsin Ave Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION
23b. DATE: JAN. 4. 1989
23c. NAME OF CEMETERY OR CREMATORY: Baltimore/Washington Crematory
23d. LOCATION CITY OR TOWN: Laurel COUNTY: P.G. STATE: Md
FUNERAL DIRECTOR: Arthur Walters ADDRESS: Takoma Funeral Home. Inc 254 Carroll St. N. W. D. C.
25a. DATE REC'D. BY REGISTRAR: JAN 5 1989
25b. REGISTRAR'S SIGNATURE: Jeanne Davidson-Randall

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

0 19747 JAN 19 89 — 1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37143 — REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal from the state.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 10

DHMH - 1650M 1/81 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST | Jean | Daniel | Lavanceau | 2a. DATE OF DEATH — MONTH DAY YEAR | 12 - 24 - 88 |
| 2b. HOUR | 2 05 PM | | | | |
| 3. SEX | Male | | | | |
| 4. RACE | White | | | | |
| 5. DATE OF BIRTH — MONTH DAY YEAR | 6 20 29 | | | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 59 YRS | | | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | France | | | | |
| 7b. CITIZEN OF WHAT COUNTRY? | U,S,A, | | | | |
| 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | | | | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH | Bethesda | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 5106 Benton Avenue | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Electronic Eng. | | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | U.S. Gov't. | | | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Bethesda | YES [X] NO [ ] | 5106 Benton Avenue 20814 |

| 14. FATHER'S NAME — FIRST / MIDDLE / LAST | Daniel | | Lavanceau | 15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST | Jeanne | | Cassou |
|---|---|---|---|---|---|---|---|

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | 1951-1953 | 579-42-5718 | Wife - Florence Lavanceau | Same as #13 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pancreatic Carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 18 Mos.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | | |

22a. I certify that (I) (this hospital) attended the deceased from Dec. 21, 19 88 to Dec. 24 19 88, that (I) (we) last saw the deceased alive on Dec. 24 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN | 22c. DATE SIGNED |
|---|---|---|---|
| R. Siena Kerwin | MD | [ ] / [X] / [ ] | Dec. 24, 1988 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| R. Siena Kerwin | #606 10400 Connecticut Ave Kensington, MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION — CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec. 30'88 | Cheltenham Veterans Cem. | Cheltenham, Maryland |

| 24. FUNERAL DIRECTOR (NAME) | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| James E. DeVol | DeVol Funeral Home, Washington, D.C. | DEC 29'88 | Julia Davidson-Randall |

016523 DEC 6 88

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR 1- STATE REGISTRAR

REG. NO. 3 3 3 7 1 4 1

1. DECEASED NAME (TYPE OR PRINT): FIRST Robert; MIDDLE L; LAST ~~Lavigne~~ LaVigne

2a. DATE OF DEATH: MONTH DAY YEAR — KNOWN XX / ESTIMATED ☐ — 12-4-88

2b. HOUR: M

3. SEX: Male

4. RACE: Caucasian

5. DATE OF BIRTH: MONTH DAY YEAR — Apr. 22, 1964

6. AGE (IN YEARS LAST BIRTHDAY): 24 YRS.

IF UNDER 1 YR. MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH DAY YEAR — 12-4-1988

2d. HOUR: 11:35 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Law Student

12b. KIND OF BUSINESS OR INDUSTRY: CatholicUniv.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Bethesda

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 5029 Allen Road 20816

14. FATHER'S NAME: FIRST Francis; MIDDLE; LAST LaVigne

15. MOTHER'S MAIDEN NAME: FIRST Mary; MIDDLE Ellen; LAST Deserre

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 102-46-6553

17. INFORMANT: (father) Francis LaVigne — ADDRESS: 57 E. Orvis St. Massena, NY 13662

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Shotgun wound of head

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR — 10:45PM 12-4-88

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): SELF INFLICTED

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): home

21f. LOCATION: STREET 5030 Allen Road, CITY OR TOWN Bethesda, COUNTY Montgomery Co. STATE MD

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide XX, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Chas P. Kokes

TITLE (SPECIFY): Acting Deputy Chief MEDICAL EXAMINER

DATE SIGNED: 12-5-88

VC EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes, M.D.

ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 9 Dec 88

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

23d. LOCATION: CITY OR TOWN Massena, NY; COUNTY; STATE

24. FUNERAL DIRECTOR: NAME Capitol Funeral Service; ADDRESS Falls Church, VA

25a. DATE REC'D. BY REGISTRAR: 12-7-88

25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

19481 JAN 18 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

88 37145 REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST MARY MIDDLE E. LAST LAW

2a. DATE OF DEATH: MONTH 12 DAY 28 YEAR 88

2b. HOUR 8:15 PM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH MAY DAY 30, YEAR 1922

6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Tennessee

7b. CITIZEN OF WHAT COUNTRY?: U.S.

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.

10. CITY OR TOWN OF DEATH: BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SUBURBAN HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret. Clerk

12b. KIND OF BUSINESS OR INDUSTRY: Real Estate

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: D.C.

13b. COUNTY

13c. CITY OR TOWN: Washington

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 4000 Massachussett Ave, NW

14. FATHER'S NAME: FIRST Nathaniel MIDDLE LAST Simerly

15. MOTHER'S MAIDEN NAME: FIRST Dora MIDDLE LAST Hartley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 412-28-6363

17. INFORMANT: Willie C Law ADDRESS: 4000 Mass Avenue, NW

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio-respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b): End stage Renal disease

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/28, 19 88, to 12/28, 19 88, that (I) (we) last saw the deceased alive on 12/28, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Javed Rahmat DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12-28-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JAVED RAHMAT

22e. ADDRESS: 5620 SHIELDS DR. BETHESDA 20817

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal

23b. DATE: 12-29-88

23c. NAME OF CEMETERY OR CREMATORY: Georgetown Med. School

23d. LOCATION: CITY OR TOWN Washington COUNTY STATE D.C.

24. FUNERAL DIRECTOR NAME: Robert G. Mason ADDRESS: Georgetown Removal Wash, D.C. 1661 Good Hope Rd. SE.

25a. DATE REC'D. BY REGISTRAR: JAN 13 1989

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Board of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

015795 DEC 12 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 37146

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified in time.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: IDA | MIDDLE | LAST: LAZANSKY | 2a. DATE OF DEATH MONTH: 12 DAY: 03 YEAR: 88 | 2b. HOUR: 10 P.M. | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH: JUNE DAY: 10 YEAR: 1905 | 6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK | 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY County MD | | |
| 10. CITY OR TOWN OF DEATH: ROCKVILLE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HEBREW HOME OF GREATER WASHINGTON | 12a. USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE): SUPERVISOR CASHIER | 12b. KIND OF BUSINESS OR INDUSTRY: GOVERNMENT SERVICES, Inc. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND | 13b. COUNTY: MONTGOMERY | 13c. CITY OR TOWN: ROCKVILLE | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 6121 MONTROSE ROAD | 20852 |
| 14. FATHER'S NAME FIRST: MORRIS MIDDLE: | LAST: COHEN | 15. MOTHER'S MAIDEN NAME FIRST: LENA MIDDLE: | LAST: GORDON | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 109-18-0468 | 17. INFORMANT: BELLA SIMON, | ADDRESS: 7137 EAST McDONALD DRIVE SCOTTSDALE, ARIZONA | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): METASTATIC CARCINOMA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 YEAR

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): OVARIAN CANCER

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. **I certify** that (I) (this hospital) attended the deceased from 9/20/ 19 88, to 12/3/ 19 88, that (I) (we) last saw the deceased alive on 12/3/ 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) ~~did~~ (did not) view the body after death.

22b. SIGNATURE: ADGod — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/4/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): D. D. PATEL — 22e. ADDRESS: 6121 MONTROSE RD, ROCKVILLE, MD

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: 12/7/1988 | 23c. NAME OF CEMETERY OR CREMATORY: MOUNT LEBANON CEMETERY | 23d. LOCATION CITY OR TOWN: ADELPHI | COUNTY: PR. GEORGES | STATE: MARYLAND |
| 24. FUNERAL DIRECTOR (NAME AND ADDRESS): DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W. WASHINGTON, D. C. | | 25a. DATE REC'D. BY REGISTRAR: DEC 09 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Lindsay | | |

BP

DHMH - 16 60M 7/73
(VR A 15(4))

019162 JAN 89 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37147 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Frances | MIDDLE: C. | LAST: Lebowitz | 2a. DATE OF DEATH MONTH DAY YEAR: 12/31/88 | 2b. HOUR: 6 12 P M | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: March 10, 1907 | 6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Czechoslovakia | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD. | | |
| 10. CITY OR TOWN OF DEATH: Wheaton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Manor Care - Wheaton | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Home | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Montgomery | Silver Spring | YES ☐ NO ☒ | 14508 Homecrest Road (20906) |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Abraham / / Czin | Miriam / / (Unknown) |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| NO | ----- | 579-54-4479 | Mordecai Lebowitz;Son;13014 Morningside Lane; Silver Spring,Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiopulmonary Arrest | 12/31 8:12 p |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Pneumonia bilat. | 12/20/88 |
| DUE TO, OR AS A CONSEQUENCE OF (c) | COPD, anemia | 9/88 |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Bronchitis Bleedy, Atrial arrhythmia, OMS

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| ☐ | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 12/15 19 88 to 12/31 19 88, that (I) (we) last saw the deceased alive on 12/31 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Arthur Schoengold | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/31/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| ARTHUR SCHOENGOLD | 18111 Prince Philip Dr Olney Md 20832 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 1/3/89 | Mt. Lebanon Cemetery | Adelphi; P.G.; Maryland |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| DANZANSKY-GOLDBERG MEMORIAL CHPLS. 1170 Rockville Pike; Rockville, Md. | JAN 6 1989 | Jane Knudson Rondeau |

BP

DHMH - 16 50M 4/83 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0016560 DEC 1988

1 - FOR STATE REGISTRAR

REG. NO. 37143

1. DECEASED NAME (TYPE OR PRINT): First Philip; Middle; Last Levin
2a. DATE KNOWN OF DEATH / ESTIMATED: Month Dec Day 13 Year 1988
2b. HOUR: 1250 P M
3. SEX: M
4. RACE: W
5. DATE OF BIRTH: Month 03 Day 11 Year 17
6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS.
IF UNDER 1 YR. MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN.
2c. DATE PRONOUNCED DEAD: Month Dec Day 13 Year 1988
2d. HOUR: 1250 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD
10. CITY OR TOWN OF DEATH: Silver Spg.
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hosp.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Pharmacist
12b. KIND OF BUSINESS OR INDUSTRY: Pharmaceuticals

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md.
13b. COUNTY: Mont.
13c. CITY OR TOWN: Chevy Chase
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS: 3203 Brooklawn Ter. 20815

14. FATHER'S NAME: First Morris; Middle; Last Levin
15. MOTHER'S MAIDEN NAME: First Dora; Middle; Last Freedman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES): N/A
16b. SOCIAL SECURITY NO.: 579-01-7825
17. INFORMANT: Anne Levin
ADDRESS: 3203 Brooklawn Terrace Chevy Chase, Md. 20815

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Dis.
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b): Chronic Myocardial Dis.
DUE TO, OR AS A CONSEQUENCE OF
(c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): None

19a. DATE OF OPERATION: None
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
21f. LOCATION STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Robert Rogers, M.D. TITLE (SPECIFY): D of P MEDICAL EXAMINER
DATE SIGNED: Dec 13 1988
EXAMINER'S NAME (TYPE OR PRINT): ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 12/15/88
23c. NAME OF CEMETERY OR CREMATORY: King David Mem. Gdns.
23d. LOCATION CITY OR TOWN; COUNTY; STATE: Falls Church, Va.

24. FUNERAL DIRECTOR NAME: Ives-Pearson Funeral Home
ADDRESS: 472 N. Washington St., Falls Church, Va.
25a. DATE REC'D. BY REGISTRAR: DEC 16 1988
25b. REGISTRAR'S SIGNATURE: Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 5000

BP

DHMH - 17
(VR A15 ME (5))

016235 DEC 15 88

FOR REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 37149

1. DECEASED NAME (TYPE OR PRINT): FIRST Florence MIDDLE Sylvia LAST Levitov

2a. DATE KNOWN OF DEATH ESTIMATED ☐: MONTH 11 DAY 25 YEAR 1988 — 2b. HOUR 10:15 AM

3. SEX: Female — 4. RACE: White — 5. DATE OF BIRTH: MONTH 7 DAY 16 YEAR 17 — 6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS. — IF UNDER 1 YR.: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

2c. DATE PRONOUNCED DEAD: MONTH 11 DAY 25 YEAR 1988 — 2d. HOUR 10:24 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): CONNECTICUT — 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD

10. CITY OR TOWN OF DEATH: Silver Spring — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1131 University Blvd #612 — 12. USUAL OCCUPATION (GIVE KIND OF WORK DURING MOST OF WORKING LIFE): JOB PLACEMENT SPECIALIST — 12b. KIND OF BUSINESS OR INDUSTRY: US EMPLOYMENT SERVICE

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD — 13b. COUNTY: Montgomery — 13c. CITY OR TOWN: Silver Spring — 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ — 13e. STREET ADDRESS: 1131 University Blvd 20902

14. FATHER'S NAME: FIRST BARNETT MIDDLE LAST COHEN

15. MOTHER'S MAIDEN NAME: FIRST LILLIAN MIDDLE LAST KRAVETZ

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 579-01-3185

17. INFORMANT: BONNIE KOUSEN — ADDRESS: 2840 FORREST LANE YORK, PENNSYLVANIA

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Cardiovascular Disease — years

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Hypertension

19a. DATE OF OPERATION: N/A — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): N/A

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Paul A. DeVore M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 11/25/88

EXAMINER'S NAME (TYPE OR PRINT): PAUL A. DEVORE, MD — ADDRESS: 42030 Queensbury Rd Hyattsville MD 20781

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: 11/27/1988 — 23c. NAME OF CEMETERY OR CREMATORY: JUDEAN MEMORIAL GARDENS — 23d. LOCATION CITY OR TOWN: OLNEY COUNTY: MONTGOMERY STATE: MARYLAND

24. FUNERAL DIRECTOR NAME AND ADDRESS: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.

25a. DATE REC'D BY REGISTRAR: NOV 29 1988 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Gardner

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

018556 JAN -9 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37150 REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Albert MIDDLE: G.D. LAST: Levy | | | | 2a. DATE OF DEATH MONTH DAY YEAR: 12 23 88 | 2b. HOUR: 2145 M |
| 3. SEX: Male | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: June 6, 1920 | 6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Berlin Germany | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH: Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Public Adm. Consultant; Pvt. Ind, | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Montgomery | 13c. CITY OR TOWN: Silver Spring | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET ADDRESS: 9702 Forest Glen Ct. (20910) | |
| 14. FATHER'S NAME FIRST: Fritz MIDDLE: LAST: Levy | | 15. MOTHER'S MAIDEN NAME FIRST: Susanna MIDDLE: LAST: Bergas | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): -------- | 16b. SOCIAL SECURITY NO.: 236-14-9875 | 17. INFORMANT (Daughter) ADDRESS: Janet Levy: 4900 Battery La. #202: Bethesda Maryland 20814 | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Stroke | 1 Day |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Thrombocytopenia | 2 mo |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Gastric Cancer | 1 year |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Anemia; Gastric bleeding; Bone marrow metastases

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from Jan 19 88 to 12/ 19 88, that (I) (we) last saw the deceased alive on 12 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Peter Sherer | DEGREE: MD | ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED: 12/ /88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Peter Sherer MD | 22e. ADDRESS: 3947 Ferrara Dr. Wheaton, md 20906 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/27/88 | 23c. NAME OF CEMETERY OR CREMATORY: Eternal Rest Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Montgomery Alabama | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: Danzansky-Goldberg Memorial Chapels 1770 Rockville Pike: Rockville, Md 20852 | 25a. DATE REC'D. BY REGISTRAR: JAN 04 1989 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

C16674 DEC 20 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37151
REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| RAE | | LEVY | DECEMBER 10, 1988 | 11:10 am |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Female | Caucasian | Feb. 6 1907 | 81 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| New York | U.S.A. | | Montgomery MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Bethesda | 6716 Melody Lane | Homemaker | Home |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Bethesda | YES ☐ NO ☒ | 6716 Melody Lane (20817) |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Maxwell | | Markowitz | Rose | | Abromowitz |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | ------- | 062-07-2020 | Daughter Rosalyn Jonas | Bethesda, Md 6716 Melody Lane |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiovascular Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cerebral Vascular Disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Diabetes Mellitus.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| ☐ ☐ | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from October, 19 85, to December, 19 1988, that (I) (we) last saw the deceased alive on 12/6, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
|---|---|---|---|
| Joel Nadler MD | MD | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | 12/11/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Joel B. Nadler | 5249 Duke St. #309: Alexandria, Va |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 12/12/88 | King David Mem. Gdn | Falls Church, Va |

| 24. FUNERAL DIRECTOR NAME AND ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Danzansky-Goldberg Memorial Chapels 1170 Rockville Pk. Rockville, Md | DEC 19 1988 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

019034 JAN 13 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37152
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Elsie | Middle: Foote | Last: L'Hommedieu | 2a. DATE OF DEATH Month/Day/Year: Decenber 24, 1988 | 2b. HOUR: 7:45 PM | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH Month/Day/Year: 4 - 18-1998 | 6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Vermont | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD. | | |
| 10. CITY OR TOWN OF DEATH: Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Meridian Health Care Center | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Home | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Montgomery | 13c. CITY OR TOWN: Silver Spring | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 14514 Kelmscot Drive 20906 | |
| 14. FATHER'S NAME First: Wallace | Middle: C. | Last: Foote | 15. MOTHER'S MAIDEN NAME First: Martha | Middle: | Last: Langworthy |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES): - - - - | 16b. SOCIAL SECURITY NO.: 213-74-4509 | 17. INFORMANT: Robert H. L'Hommedieu | ADDRESS: 6302 Evermay Dr. 22101 McLean, Virginia | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Stroke — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): Cerebro Vascular Disease

DUE TO, OR AS A CONSEQUENCE OF (c): Atrial Fibrillation

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____ 19 24, to 12 - 24 19 88, that (I) (we) last saw the deceased alive on 11-28 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Alberto Rotsztain — DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: Dec. 26, 1988

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. Alberto Rotsztain, M. D. — 22e. ADDRESS: 10401 Old Georgetown Road Bethesda, MD 20814

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/28/88 | 23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery | 23d. LOCATION CITY OR TOWN: Brentwood | COUNTY: Pr. George's | STATE: MD |
| 24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons, Inc. ADDRESS: 5130 Wisconsin Ave.,NW, Washington, DC 20016 | | 25a. DATE REC'D BY REGISTRAR: DEC 28 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

BP 20

DHMH - 1650M 1/81 (VRA 15, 4)

013752 NOV 1988

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37153 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Cleared by Med. Examiner.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | Richard G. Lichens | 2a. DATE OF DEATH MONTH DAY YEAR | NOV. 3 1988 |
| 2b. HOUR | 4 44 P M | | |
| 3. SEX | Male | 4. RACE | White |
| 5. DATE OF BIRTH MONTH DAY YEAR | April 22, 1929 | 6. AGE (IN YEARS LAST BIRTHDAY) | 59 YRS |
| IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS: HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | WASH. D.C. | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. |
| 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | | 9. BALTIMORE CITY OR COUNTY OF DEATH | Montgomery MD. |
| 10. CITY OR TOWN OF DEATH | Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Holy Cross Hospital |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | SPECIALIST | 12b. KIND OF BUSINESS OR INDUSTRY | Motion Pictures |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | MD | 13b. COUNTY | Montgomery |
| 13c. CITY OR TOWN | Silver Spring | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | |
| 13e. STREET ADDRESS | 8913 First Ave. 20910 | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | SAMUEL LICHENS | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | FANNIE BECKER |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | YES | (IF YES, GIVE WAR OR DATES) | KOREAN |
| 16b. SOCIAL SECURITY NO. | 578.44.9328 | 17. INFORMANT ADDRESS | MRS SHARON L. LICHENS (SAME AS #13) |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO Respiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 hour

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial INFARCTION

DUE TO, OR AS A CONSEQUENCE OF (c) Possible Ventriculum Rupture

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from NOV 3, 19 88, to NOV 3, 19 88, that (I) (we) last saw the deceased alive on NOV 3, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I)(we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Richard Gelfand MD | DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED 11/3/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | RICHARD GELFAND | 22e. ADDRESS | 5620 Shields Drive, Bethesda, Md 20817 |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | CREMATION | 23b. DATE | 11/7/1988 | 23c. NAME OF CEMETERY OR CREMATORY: CHAMBERS CREM. |
| 23d. LOCATION CITY OR TOWN / COUNTY / STATE | RIVERDALE, PG.C., Md. | | | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | W. W. CHAMBERS CO. INC. SILVER SPRING, Md | 25a. DATE REC'D. BY REGISTRAR | NOV 14 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH - 16 50M 1/81 (VRA 15, 4)

017410 DEC 28 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

88 REG. NO. 37154

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the [illegible] and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remit the certificate, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: ELIZABETH | MIDDLE: L. | LAST: LIGON | 2a. DATE OF DEATH MONTH DAY YEAR: DECEMBER 22 1988 | 2b. HOUR: 10:30 PM |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR: NOV. 16, 1892 | 6. AGE (IN YEARS LAST BIRTHDAY): 96 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD | |
| 10. CITY OR TOWN OF DEATH: SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MERIDIAN NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER | 12b. KIND OF BUSINESS OR INDUSTRY: HOME |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MD. | MONT. | ASHTON | YES ☒ NO ☐ | 316 ASHTON ROAD 20861 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|---|
| CHARLES R. HARTSHORNE | ELLA - LANSDALE | NO | 220-46-7889 | CHARLES H. LIGON SANDY SPRING, MD. 20860 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | ACUTE CARDIO RESP. ARREST | TERM |
| DUE TO, OR AS A CONSEQUENCE OF (b) | CONGESTIVE HEART FAILURE | TERM |
| DUE TO, OR AS A CONSEQUENCE OF (c) | A.S.C.V.D. | YRS |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 11/27 19 88 to 12/22 19 88, that (I) (we) last saw the deceased alive on 11/27 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN ☒ / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|---|
| Donald R. Lewis MD | MD | | 12/23/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DONALD R. LEWIS MD | OLNEY MARYLAND |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| CREMATION | DEC. 23, 1988 | BALT. WASH. CREMATORY | LAUREL P. GEORGE MD. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| MURIEL H. BARBER LAYTONSVILLE, MD. 20879 | DEC 27 1988 | [signature] |

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

(8)

17180 DEC 27 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT - If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

R BP

DHMH - 16 60M 7/84 (VRA 15, 4)

1 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

88 REG. NO. 37155

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Josephine MIDDLE: Yolanda LAST: Lisanti | | | | 2a. DATE OF DEATH MONTH 12 DAY 16 YEAR 88 | 2b. HOUR 0600 A.M. |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH 01 DAY 22 YEAR 22 | 6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD | | |
| 10. CITY OR TOWN OF DEATH: Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST Hosp | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Office Clerk | 12b. KIND OF BUSINESS OR INDUSTRY: Lord & Taylor | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: P.G. | 13c. CITY OR TOWN: College Park | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET ADDRESS / ZIP CODE: 9124 Autoville Drive 20740 | |
| 14. FATHER'S NAME FIRST: Dominick MIDDLE LAST: Savial | | 15. MOTHER'S MAIDEN NAME FIRST: Rose MIDDLE LAST: Miceli | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 579-28-8506 | 17. INFORMANT: Anthony Lisanti | ADDRESS: 9124 Autoville Drive College Park, MD 20740 | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): (1) Generalized Arteriosclerosis (2) Epilepsy

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ] | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 4/15, 19 87, to 12/16, 19 88, that (I) (we) last saw the deceased alive on 12/15, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Alan R Gair | DEGREE: MD | ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED: 12/16/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Alan R. Gair MD | 22e. ADDRESS: 11700 Old Columbia Pike Silver Spring, Md 20904 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/19/88 | 23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery | 23d. LOCATION CITY OR TOWN: Cumberland | COUNTY: Allegany STATE: MD |
| 24. FUNERAL DIRECTOR NAME: Francis Gasch's Sons Funeral Home, PA ADDRESS: 4739 Baltimore Avenue, Hyattsville, MD 20781 | | 25a. DATE REC'D. BY REGISTRAR: DEC 19 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

015880 DEC 12 88

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 88 3715 6

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST: Kerry | MIDDLE: David | LAST: Lloyd | 2a. DATE OF DEATH KNOWN XX / ESTIMATED ☐ MONTH: 8 DAY: 27 YEAR: 1988 | 2b. HOUR: 2:15 AM |
| 3. SEX: Male | 4. RACE: Cauc. | 5. DATE OF BIRTH MONTH DAY YEAR: Sept. 29, 1941 | 6. AGE (IN YEARS) LAST BIRTHDAY: 46 YRS. | IF UNDER 1 YR. MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: August 27, 88 | 2d. HOUR: 2:15 AM |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Michigan | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH: Rockville | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Computer Program Analyst | 12b. KIND OF BUSINESS OR INDUSTRY: COMSAT | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Montgomery | 13c. CITY OR TOWN: Gaithersburg | 13d. INSIDE CITY LIMITS? YES X NO ☐ | 13e. STREET ADDRESS: 18616 Grosbeak Terrace 20879 | | |
| 14. FATHER'S NAME FIRST: Kenneth | MIDDLE: B. | LAST: Lloyd | 15. MOTHER'S MAIDEN NAME FIRST: Marriette | MIDDLE | LAST: Feguin | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): None | 16b. SOCIAL SECURITY NO.: 216-40-5430 | 17. INFORMANT: Anne Lloyd | ADDRESS: 18616 Grosbeak Terrace Gaithersburg, Md. 20879 | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ACUTE
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): ARTERIOSCLERATIC CARDIOVASCULAR DISEASE — INDEF
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

| | | |
|---|---|---|
| 19a. DATE OF OPERATION: — | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?: — | 20. AUTOPSY? YES ☐ NO ☑ |
| 21a. EXTERNAL CAUSE WAS UNDERLYING ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: 08 A.M. 8 27 1988 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): COLLAPSED AT HOME |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): HOME | 21f. LOCATION STREET: 18616 Grosbeak Terr CITY OR TOWN: Gaithersburg COUNTY: Mont STATE: Md |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Frances C. Mayle M.D. TITLE (SPECIFY): Dept MEDICAL EXAMINER DATE SIGNED: DUP. 8/27/88

EXAMINER'S NAME (TYPE OR PRINT): FRANCES C MAYLE ADDRESS: 8100 Wisconsin Ave. Bethesda MD

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal | 23b. DATE: Aug. 27, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: Geo. Wash. Medical School | 23d. LOCATION CITY OR TOWN: Washington COUNTY: D.C. STATE: |
| 24. FUNERAL DIRECTOR NAME: Columbia Mortuary Services 225 Missouri Ave. N.W. Washington D.C. | | 25a. DATE REC'D. BY REGISTRAR: DEC 8 - 1988 | 25b. REGISTRAR'S SIGNATURE: Davidson Randall |

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 88 37157

DECEASED NAME (TYPE OR PRINT): FIRST Daniel MIDDLE T. LAST Long.

2a. DATE OF DEATH: MONTH Nov DAY 3 YEAR 1988 — 2b. HOUR — A.M.

3. SEX: Male.

4. RACE: White.

5. DATE OF BIRTH: MONTH MAY DAY 1. YEAR 1906

6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): SOUTH CAROLINA

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: SILVER SPRING

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SPRINGVALE TERRACE

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RESTAURANT OWNER

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD — 13b. COUNTY: MONT — 13c. CITY OR TOWN: SILVER SPRING — 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e. STREET ADDRESS: 8505 SPRINGVALE TERRACE 20910

14. FATHER'S NAME: FIRST MATTHEW MIDDLE LAST LONG

15. MOTHER'S MAIDEN NAME: FIRST MINNIE MIDDLE LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 577-09-2231

17. INFORMANT: MARGARET MacDONALD — ADDRESS: GAITHERSBURG MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac arrest sudden death - possible coronary embolism — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hr.

DUE TO, OR AS A CONSEQUENCE OF (b): Cardiovascular disease — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): peripheral vascular disease

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2):

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION: STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) this hospital) attended the deceased from 1986 to 1988, that (I) we) last saw the deceased alive on 1987 19 88, and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) we) (did (did not) view the body after death.

22b. SIGNATURE: Sanford H. Richman, MD — DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 11/4/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Sanford Richman, M.D.

22e. ADDRESS: 11500 Old Georgetown Rd Rockville, MD 20852

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation. — 23b. DATE: Nov. 4 1988 — 23c. NAME OF CEMETERY OR CREMATORY: B. and W. Crematory — 23d. LOCATION CITY OR TOWN: Laurel. P. G. COUNTY Co. Md. STATE

24a. FUNERAL DIRECTOR: Arthur Walters — ADDRESS: Takoma Funeral Home. 254 Carroll St. N. W.

25a. DATE REC'D. BY REGISTRAR: NOV. 7 1988 — REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37153 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | |
|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | First: Elizabeth Middle: M Last: Long |
| 2a. DATE OF DEATH | Month/Day/Year: 12/02/88 |
| 2b. HOUR | 20:51 M |
| 3. SEX | FEMALE |
| 4. RACE | White |
| 5. DATE OF BIRTH | Month/Day/Year: 06/16/93 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 95 YRS; If under 1 year: Months / Days; If under 24 hrs.: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | GEORGIA |
| 7b. CITIZEN OF WHAT COUNTRY? | USA |
| 8. | MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Montgomery MD. |
| 10. CITY OR TOWN OF DEATH | Silver Spring |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Holy Cross Hospital of S.S. |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | REG. NURSE |
| 12b. KIND OF BUSINESS OR INDUSTRY | HOSPITAL |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Md. |
| 13b. COUNTY | Montgomery |
| 13c. CITY OR TOWN | Silver Spring |
| 13d. INSIDE CITY LIMITS? | YES ☐ NO ☐ |
| 13e. STREET ADDRESS | 2821 Hathaway Terr. 20906 |
| 14. FATHER'S NAME | First: ALBERT Middle: Last: MUNISCH |
| 15. MOTHER'S MAIDEN NAME | First: ANNIE Middle: L. Last: THOMAS |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | No |
| 16b. IF YES, GIVE WAR OR DATES | |
| 16b. SOCIAL SECURITY NO. | 579-32-2533 |
| 17. INFORMANT | 3 - THOMAS F. LARKIN - AVE. T. P. DD |
| ADDRESS | 8201 FLOWER |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Acute Cardiorespiratory arrest | sudden |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Arteriosclerotic Cardiovascular Disease | 10 yrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/1 19 88, to 12/2 19 88, that (I) (we) last saw the deceased alive on 12/2 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Myron L Lenkin | DEGREE MD | ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ |
| 22c. DATE SIGNED | 12/13 88 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | MYRON L. LENKIN | 22e. ADDRESS | 2309 SHOREFIELD RD WHEATON, MD. |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY / STATE |
| Burial. | 12/5/88 | George Washington | Riggs Rd. Hyattsville, | P. G. Co. Md. |
| 24. FUNERAL DIRECTOR | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE | |
| Arthur Waters | Takoma Funeral Home. 254 Carroll St. N. W. D. C. | DEC 8 - 1988 | Jane Davidson-Randall | |

BP

DHMH - 1650M 1/81 (VRA 15, 4)

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FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO 88 37159

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Gabriel | | Lopez | 12 14 88 | 11:50 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
|---|---|---|---|---|---|
| Male | Caucasian | October 21 1967 | 21 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Mexico | Mexico | | Montgomery MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Takoma Park | Washington Adventist Hospital | Laborer | Construction |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Mont. Co. | Silver Spring | YES ☒ NO ☐ | 1010 Quebec Terrace #802 20903 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Lucio | Chavez | | Avelina | Lopez | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | None | Amado Cruz 1010 Quebec Terrace, | Silver Spring Md |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Brain Death | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Subarachnoid bleed | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Cerebral Aneurysm. | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 12-13, 1988, to 12-14-, 1988, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| [illegible] 1106 Irving St. N.W. #412 | Wash, D.C. 20010 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Removal | Dec. 20, 1988 | | Santa Ana, Mexico |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| McGuire Funeral Service 7400 Georgia Ave. Washington, D.C. | DEC 19 '88 | Julia Davidson-Rondelle |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once

DHMH - 16 50M 1/81 (VRA 15, 4)

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 037160

| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|
| ELIZABETH MARKWITH LOWE | DECEMBER 14, 1988 | 12:30 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | CAUCASIAN | JUNE 28, 1914 | 74 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | UNITED STATES | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | MONTGOMERY COUNTY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| GAITHERSBURG | 20015 LUMARYN PLACE, 20879 | HOMEMAKER | OWN HOME |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MARYLAND | MONTGOMERY | GAITHERSBURG | YES [ ] NO [X] | 20015 LUMARYN PLACE, 20879 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| HOWARD S. MARKWITH | ELIZABETH IZETTA (UNKNOWN) |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| NO | | 578-72-3671 | ARTHUR LOWE, JR. 20015 LUMARYN PLACE, GAITHERSBURG, MARYLAND 20879 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MINUTES

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) SEVERE ALZHEIMERS SYNDROME — MONTHS

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

HYPERLIPIDEMIA, recent onset of seizure disorder due to Alzheimers syndrome

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| [ ] | | |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | | |

22a. I certify that (I) (~~this hospital~~) attended the deceased from March 17, 1987 to December 14, 1988, that (I) (~~saw~~) last saw the deceased alive on December 9, 1988, and that in (my) (~~his~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~have~~) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | 22c. DATE SIGNED |
|---|---|---|---|---|
| Byrl D. Johnson | MD | ATTENDING PHYSICIAN [X] | MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | DECEMBER 14, 1988 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Byrl D. Johnson, M.D. | 911 Russell Avenue Gaithersburg, Md.20879 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| CREMATION | DECEMBER 14, 1988 | MONTGOMERY CREMATORIUM, INC. | BETHESDA, MONTGOMERY, MD |

24. FUNERAL DIRECTOR NAME: ROBERT A. PUMPHREY FUNERAL HOME, BETHESDA-CHEVY CHASE, INC.
7557 WISCONSIN AVE. BETHESDA, MARYLAND 20814

25. DATE RECD. BY REGISTRAR: DEC 15 88

REGISTRAR'S SIGNATURE: Julia Davidson Pondelik

0 1 4 5 2 5 NOV 28 88

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 5 8 3 7 1 6 1

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| BERNARD | A. | LOWRY | NOVEMBER 19, 1988 | 7:35P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN |
|---|---|---|---|---|---|
| MALE | CAUCASIAN | DEC 20 1911 | 76 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| WASHINGTON, DC | USA | | MONTGOMERY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| SILVER SPRING | 3917 HAVARD STREET | SALESMAN-AUTO | MD MOTORS |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MARYLAND | MONTGOMERY | SILVER SPRING | YES ☐ NO ☐ | 3917 HAVARD STREET 20906 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| WILLIAM | ASHTON | LOWRY | ANNA | | GALLAGHER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| YES | WWII | 577-07-5944 | IDA R. LOWRY/WIFE/SAME AS 13 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of prostate with
DUE TO, OR AS A CONSEQUENCE OF (b) widespread metastases
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1981

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cerebrovascular accident, old

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| ☐ ☐ | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 5/16 19 75, to 11/19 19 88, that (I) (we) last saw the deceased alive on 11/18 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE DEGREE | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|
| George Kenton, MD | | 11/20/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| GEORGE S. KENTON | 10620 Georgia Ave, SS, MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| BURIAL | NOV 23, 1988 | GATE OF HEAVEN CEM. | SILVER SPRING MONTGOMERY MD |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE RECD. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| FRANCIS J. COLLINS, JR. | 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901 | NOV 25 1988 | Gloria Faller Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

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FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37162 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Margaret | Middle: O'Donnoghue | Last: Lubore | 2a. DATE OF DEATH Month/Day/Year: December 3, 1988 | 2b. HOUR: 12:30AM | |
| 3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH Month/Day/Year: March 8, 1908 | 6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, DC | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD. | | |
| 10. CITY OR TOWN OF DEATH: Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Nursing Center | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Statistician | 12b. KIND OF BUSINESS OR INDUSTRY: Dept. of Agriculture | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Derwood | YES ☐ NO ☒ | 17556 Wheat Fall Drive/20855 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|---|
| John / Harding / O'Donnoghue, Sr. | Margaret / L. / Schmitt | no | 579-48-5991 | Mary Louise Grinder, same as #13 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO, OR AS A CONSEQUENCE OF

(b) Ischemic heart disease — years

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Electrolyte and fluid malabsorption due to short bowel syndrome due to surgical small bowel resection

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (~~this hospital~~) attended the deceased from ____ 19 87 to December 3 19 88, that (I) (~~we~~) last saw the deceased alive on 12/1 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
|---|---|---|---|
| Byrl D. Johnson | M.D. | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | December 5, 1988 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Byrl Johnson, M.D. | 911 North Russell Avenue Gaithersburg, Maryland 20879 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec.7, 1988 | Ft. Lincoln Cemetery | Brentwood, Maryland |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Ave., Rockville, MD 20850 | DEC 5 '88 | Julia Davidson-Randall |

DHMH - 16 50M 1/81 (VRA 15, 4)

12977 NOV 14 88

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37163
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR | |
| William | S. | Lumsden Jr. | 11/4/88 | 1:01 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
| Male | Caucasian | 9 8 04 | 84 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Tennessee | United States | | Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Silver Spring MD | Holy Cross Hospital | Truck Driver | Food | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Virginia | Spotsylvania | Fredericksburg | YES ☐ NO ☐ | 33 Ocala Lane/22401 99999 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| William | S. | Lumsden Sr. | Cora | | Anderson |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | | 577-05-5140 | Robert D. Lumsden (Son) 13609 Lewisdale Road Clarksburg, Maryland 20871 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: immediate

DUE TO, OR AS A CONSEQUENCE OF (b) chronic obstruction pulmonary disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| ☐ | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (~~the hospital~~) attended the deceased from ____, 19 84, to NOV 4, 19 88, that (I) (~~last~~) saw the deceased alive on NOV 3, 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~last~~) (did not) view the body after death.

22b. SIGNATURE — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: NOV 4 1988

22d. PHYSICIAN'S NAME (TYPE OR PRINT): WALTER E. GOOTH MD

22e. ADDRESS: 2309 SHOREFIELD RD WHEATON MD

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | November 7, 1988 | Ft. Lincoln Cemetery | Brentwood, | Maryland | |

24. FUNERAL DIRECTOR NAME: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850

25a. DATE REC'D. BY REGISTRAR: NOV 9 1988

25b. REGISTRAR'S SIGNATURE

IMPORTANT: TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

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016291 DEC 15 88

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 37164

1. DECEASED NAME (TYPE OR PRINT): FIRST Carrie MIDDLE E LAST Lusby
2a. DATE OF DEATH: MONTH 12 DAY 13 YEAR 88
2b. HOUR 7:10 PM
3. SEX: F
4. RACE: W
5. DATE OF BIRTH: MONTH 3 DAY 31 YEAR 09
6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Silver Spring
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Teacher-Montgomery Cty.
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md.
13b. COUNTY: Mont.
13c. CITY OR TOWN: S.S.
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 3132 Briggs Chaney Road 20904

14. FATHER'S NAME: FIRST A. MIDDLE Randolph LAST Robey
15. MOTHER'S MAIDEN NAME: FIRST Sarah MIDDLE LAST Harrison
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A
16b. (IF YES, GIVE WAR OR DATES):
16b. SOCIAL SECURITY NO.: 217 30 6922
17. INFORMANT ADDRESS: 22 Daniel Boone Trail
William Lusby(Son) Serverne, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: few minutes
DUE TO, OR AS A CONSEQUENCE OF (b): Aspiration
DUE TO, OR AS A CONSEQUENCE OF (c): Dementia and debilitation
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
912

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cardiovascular debilitation

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR, A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2):
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 11-28 19 88, to 12-13 19 88, that (I) (we) last saw the deceased alive on 12-13 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Norman S. Kovac
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12-13-88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): NORMAN S. KOVAC MD
22e. ADDRESS: 10313 Georgia Ave SS MD 20902

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 12/17/88
23c. NAME OF CEMETERY OR CREMATORY: Union Cemetery
23d. LOCATION CITY OR TOWN: Burtonsville COUNTY: Mont. Md.
24. FUNERAL DIRECTOR NAME AND ADDRESS: Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md.
25a. DATE REC'D. BY REGISTRAR: DEC 14 1988
25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1650M 1/81 (VRA 15, 4)

014402 NOV 25 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 037165

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Harold | Middle: S. | Last: Lutz | 2a. DATE OF DEATH Month/Day/Year: 11-19-88 | 2b. HOUR: 4:30 AM | |
| 3. SEX: M | 4. RACE: Caucasion | 5. DATE OF BIRTH Month/Day/Year: 11 20 16 | 6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS | IF UNDER 1 YEAR Months/Days | IF UNDER 24 HRS Hours/Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH: Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Hosp. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): self employed | 12b. KIND OF BUSINESS OR INDUSTRY: Hauling | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Montgomery | 13c. CITY OR TOWN: Boyds | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET ADDRESS: 230 Old Bucklodge Lane | 20841 |
| 14. FATHER'S NAME First: George | Middle: Lewis | Last: Lutz | 15. MOTHER'S MAIDEN NAME First: Goldie | Middle: Johnson | Last: Ruthvin |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 578-20-2979 | 17. INFORMANT ADDRESS: Helen Kennan, Monrovia, MD | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | Approximate interval between onset and death |
|---|---|---|
| IMMEDIATE CAUSE (a) | RESPIRATORY FAILURE | 15 MIN |
| DUE TO, OR AS A CONSEQUENCE OF (b) | PNEUMONIA | 5 DAYS |
| DUE TO, OR AS A CONSEQUENCE OF (c) | CHRONIC OBSTRUCTIVE PULMONARY DISEASE | 10 YEARS |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: SEIZURE DISORDER, HEMOLYTIC ANEMIA

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |

| | | |
|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) this hospital) attended the deceased from NOV 9, 1988, to NOV 18 1988, that (I) we) last saw the deceased alive on NOV 18 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) we) (did) did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: S T Kenny — | DEGREE: MD | ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED: 11/19/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): STEVEN T. KARVA, MD | 22e. ADDRESS: 4701 RANDOLPH RD # G3, ROCKVILLE MD 20852 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 21 NOV 88 | 23c. NAME OF CEMETERY OR CREMATORY: Boyd Presby Ch Cem | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Boyds Montgomery MD | |
| 24. FUNERAL DIRECTOR NAME: Robert A. DeVol | ADDRESS: DeVol Funeral Home Gaithersburg, MD | 25a. DATE REC'D BY REGISTRAR: NOV 22 1988 | 25b. REGISTRAR'S SIGNATURE: | |

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

014129 NOV 22 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked, or if there is any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 37166

| 1. DECEASED NAME (TYPE OR PRINT) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Anh | Thoai | Luong | 11 15 88 | 0140 M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH Month Day Year | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS Hours / Min. |
|---|---|---|---|---|---|
| Female | Oriental | Aug. 29, 1916 | 72 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| China | China | MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | Montgomery County, MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Rockville | Shady Grove Adventist Hospital | Homemaker | Own Home |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Rockville | YES ☒ NO ☐ | #5 Lawrence Court 20850 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Not | Available | | Not | Available | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 220-04-6508 | Quynh Chau daughter | 394 N. Summit Ave. #204 Gaithersburg, Md. |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiorespiratory Arrest | minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Cirrhosis of Liver | months |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Hepatitis B | years |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 11-6, 19 88, to 11-15, 19 88, that (I) (we) last saw the deceased alive on 11-14, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | Nov. 15, 1988 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Daniel Salter, M.D. | 19511 Doctors Dr. Germantown, MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | Nov. 16, 1988 | Montgomery Crematorium | Bethesda, Maryland |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Robert A. Pumphrey Funeral Home, Inc. | 300 West Montgomery Avenue Rockville, Maryland 20850 | NOV 21 1988 | Julia Davidson-Randall |

014516 NOV 28 88

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37167 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | William / / Lyles | 2a. DATE OF DEATH MONTH DAY YEAR | November 14, 1988 | 2b. HOUR | 1:00 PM |
| 3. SEX | Male | 4. RACE | Black | 5. DATE OF BIRTH MONTH DAY YEAR | Mar 1, 1889 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 99 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Maryland | 7b. CITIZEN OF WHAT COUNTRY? | USA | 8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐ | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | MONTGOMERY | | | | MD. |
| 10. CITY OR TOWN OF DEATH | Clarksburg | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 14220 Comus Road | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Dog Trainer |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MD | Montg. | Clarksburg | YES ☐ NO ☐ | 14220 Comus Rd. 20871 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Unknown | Emma ? Giddings |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | World WI | Unk | Mrs Mabel Crutchfield (Guardian) | Same As 13#E |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Severe vascular disease, including coronary/cerebral.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Right femoral embolus; gangrenous foot. Status post femoral embolectomy; above knee amputation.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | Gangrenous Foot. | YES ☐ NO ☑ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Joseph L. Mayo MD | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑ | 11/17/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Joseph L. Mayo, M.D. | 18111 Prince Phillip Dr., Olney, MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 11-18-88 | Lincoln Park Cem. | Rockville, Montg, Md |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| George R. Snowden | 246 N. Washington St, Rockville, Md | NOV 23 1988 | |

V.A. BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

014678 NOV 30-88 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37168 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First / Middle / Last: JOHN JOSEPH LYNCH | | | | 2a. DATE OF DEATH Month Day Year: NOVEMBER 21 1988 | 2b. HOUR: 12:45 P M |
| 3. SEX: MALE | 4. RACE: CAUCASIAN | 5. DATE OF BIRTH Month Day Year: OCTOBER 21 1911 | 6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS | If under 1 year: Months / Days | If under 24 hrs: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MASSACHUSETTS | 7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES | 8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH: BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY: U.S.NAVY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: DISTRICT OF | 13b. COUNTY: COLUMBIA | 13c. CITY OR TOWN: Washington,DC | 13d. INSIDE CITY LIMITS? YES X NO ☐ | 13e. STREET ADDRESS: 5025 HAWTHORNE PLACE, NW 20016 | |
| 14. FATHER'S NAME First / Middle / Last: PATRICK LYNCH | | 15. MOTHER'S MAIDEN NAME First / Middle / Last: NORA SCANLON | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES | (IF YES, GIVE WAR OR DATES): 1935-1970 | 16b. SOCIAL SECURITY NO.: 031-30-1121 | 17. INFORMANT ADDRESS: VIRGINIA B. LYNCH,5025 HAWTHORNE PLACE,NW | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) WASHINGTON, DC 20016

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): METASTATIC PROSTATE CARCINOMA — Approximate interval between onset and death:

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO X | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 30 19 88 to NOVEMBER 21 19 88, that (I) (we) last saw the deceased alive on NOVEMBER 21 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Mark S. Georgiadis | DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN X | | 22c. DATE SIGNED: 11/22/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): MARK S. GEORGIADIS, LT, MC, USNR | | 22e. ADDRESS: NAVAL HOSPITAL BETHESDA, MD 20814-5011 | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Nov.25,1988 | 23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat.Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Arlington,Virginia | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: DeVol Funeral Home 2222 Wisc.Ave.,NW Wash,DC | | 25a. DATE RECD BY REGISTRAR: NOV 28 1988 | 25b. REGISTRAR'S SIGNATURE | |

DHMH - 1650M 1/81 (VRA 15, 4)

0 1 4 1 9 8 NOV 22 88 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

88 37169 REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH | DAY | YEAR / 2b. HOUR |
| Norman | S. | Lynch | 11 | 15 | 88 / 6:30 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH | DAY | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|---|---|
| Male | Black | 08 | 28 | 38 | 50 YRS. | | | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| D.C. | U.S. | | Montgomery Co. MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Silver Springs Md. | Holy Cross Hospital | practical nurse | Health |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Silver Spring | YES ☐ NO ☐ | 12605 Billington Rd. |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Frank | W. | Lynch | Louise | | Johnson |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 579-44-7479 | Ms. Lola Simmons/sister/same | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) BRAIN DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) Intracerebral Hemorrhage

DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 11-8-, 19 88, to 11-15, 19 88, that (I) (we) last saw the deceased alive on 11-15-, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Tony P. Kannarkat | MD | ATTENDING PHYSICIAN ☐ | MEDICAL DIRECTOR ☒ | STAFF PHYSICIAN ☐ | 11/16/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Tony P. Kannarkat. MD. | 8201 16th St, Silver Spring, MD 20910 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | 11-19-88 | Lincoln Memorial | Suitland, | | Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| John T. Rhines Co., 3015 12th St. N.E., D.C. 20017 | NOV 21 1988 | Julia Davidson-Rondelle |

0 19756 JAN 1989

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP XX

DHMH - 1650M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

58 37170 REG. NO.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Harry Clifford MacFate, Jr. | | 2a. DATE OF DEATH MONTH DAY YEAR: December 25, 1988 | 2b. HOUR: 9:20P M |
| 3. SEX: Male | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: July 16, 1902 | 6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C. | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD. |
| 10. CITY OR TOWN OF DEATH: Chevy Chase | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 4450 S. Park Avenue, #1803 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerical | 12b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Chevy Chase | YES ☐ NO ☒ | 4450 S. Park Avenue, #1803 Zip: 20815 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | |
|---|---|---|
| Harry Clifford MacFate | Eva Celest Small | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): - | 16b. SOCIAL SECURITY NO.: 577-60-3741 |
| 17. INFORMANT: Miss Barbara Lynn MacFate, Daughter, | ADDRESS: Same as #13 | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiorespiratory Arrest | 10 Minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Arteriosclerotic Heart Disease | 10 years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) ~~XXXXXXX~~ attended the deceased from June 1, 19 88, to December 25 19 88, that (I) ~~XXX~~ last saw the deceased alive on December 23, 19 88, and that in (my) ~~XXX~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~XXX~~ (did) (~~did not~~) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| J. Neill Kennedy M.D. | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | Dec.26,1988 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| J. Neill Kennedy, M.D. | 1145 19th Street, N.W. Washington, D.C. 20036 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | December 28, 1988 | Columbia Gardens | Arlington Co., Virginia |

| 24. FUNERAL DIRECTOR NAME | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland | DEC 30 '88 | Julia Davidson-Randall |

014132 NOV 2 1988

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO: 88 037171

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Alex | MIDDLE | LAST: Machlis | 2a. DATE OF DEATH MONTH: 11 DAY: 15 YEAR: 88 | 2b. HOUR: 10:52PM M | |
| 3. SEX: Male | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: Dec. 20, 1909 | 6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Poland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH: OLney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Business Owner (Ret.) Grocery | 12b. KIND OF BUSINESS OR INDUSTRY: Store | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Montgomery | 13c. CITY OR TOWN: Rockville | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET ADDRESS: 12630 Viers Mill Rd.,#1219 (20853) | |
| 14. FATHER'S NAME FIRST: Beryl | MIDDLE | LAST: Machlis | 15. MOTHER'S MAIDEN NAME FIRST: Lena | MIDDLE | LAST |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES): --------- | 16b. SOCIAL SECURITY NO.: 051-09-2199 | 17. INFORMANT ADDRESS: Gaithersburg, Md. 20879 | Gloria Heyman; Daughter; 14 Doolittle Court; | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pulmonary Embolus

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ] | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from Nov 12, 19 88, to Nov 15, 19 88, that (I) (we) last saw the deceased alive on Nov 15, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Gregory H. Fisher | DEGREE: MD | ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED: NOV 16, 1988 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Gregory H. Fisher | 22e. ADDRESS: 15225 Shady Grove Rd. Suite 201 Rockville, Md 20850 | | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 11/18/88 | 23c. NAME OF CEMETERY OR CREMATORY: Mt. Lebanon Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Adelphi; P.G.; Maryland |
| 24. FUNERAL DIRECTOR NAME: DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS: 1170 Rockville Pike; Rockville, Md. 20852 | 25a. DATE REC'D. BY REGISTRAR: NOV 21 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall | |

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

015620 DEC - 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

S B 3 7 1 7 2
REG NO.

1 DECEASED NAME (TYPE OR PRINT): FIRST ALVIN MIDDLE S LAST MACK

2a DATE OF DEATH: MONTH 12 DAY 2 YEAR 88

2b HOUR 12:38 P.M.

3 SEX: M

4 RACE: B

5 DATE OF BIRTH: MONTH 9 DAY 06 YEAR 15

6 AGE (IN YEARS LAST BIRTHDAY): 73 YRS

# UNDER 1 YEAR: MONTHS DAYS

# UNDER 24 HRS: HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON, D.C.

7b CITIZEN OF WHAT COUNTRY? UNITED STATES

8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9 BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES MONT MD.

10 CITY OR TOWN OF DEATH: TAKOMA PARK

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET, ADDRESS): WASHINGTON ADVENTIST HOSP.

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ELECTRONIC ENGINEER

12b KIND OF BUSINESS OR INDUSTRY: PRIVATE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a STATE: MARYLAND

13b COUNTY: PRINCE GEORGES

13c CITY OR TOWN: UPPER MARL.

13d INSIDE CITY LIMITS? YES [X] NO [ ]

13e STREET ADDRESS: #29 BARBERRY CT. 20772

14 FATHER'S NAME: FIRST HENRY MIDDLE LAST MACK

15 MOTHER'S MAIDEN NAME: FIRST EMMA MIDDLE LAST THOMAS

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES

(IF YES, GIVE WAR OR DATES): 7/42 - 7/44

16b SOCIAL SECURITY NO.: 709-12-4691A

17 INFORMANT: ELEANOR MACK

ADDRESS: #29 BARBERRY CT. UPPER MARLBORO, MD.

## MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Cardiac and Respiratory Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Extensive prostate Cancer with met

DUE TO, OR AS A CONSEQUENCE OF (c): Malnutrition 2° #2

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY? YES [ ] NO [ ]

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]

21b TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION: STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from 11/8/88 19__ to 12/2/88 19__ that (I) (we) last saw the deceased alive on 12/2 19 88 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: Mark S. Hd

DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c DATE SIGNED: 12/2/88

22d PHYSICIAN'S NAME (TYPE OR PRINT): SMITH MD

22e ADDRESS: 7610 Carroll Ave Takoma Pk md 20912

23a BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b DATE: 12-8-88

23c NAME OF CEMETERY OR CREMATORY: HARMONY CEMETERY

23d LOCATION: CITY OR TOWN LANDOVER, COUNTY MARYLAND STATE

24 FUNERAL DIRECTOR: NAME Pope FUNERAL Home ADDRESS 2617 PENNSYLVANIA Ave. S.E.

25a DATE REC'D BY REGISTRAR: DEC 5 - 1988

25b REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or physician.

TO FUNERAL DIRECTOR: The certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use with the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP____

DHMH - 16 50M 1/81 (VRA 15, 4)

015083 DEC -2 88

FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

REG. NO. 88 037173

| 1. DECEASED NAME (TYPE OR PRINT) | FIRST | MIDDLE | LAST |
|---|---|---|---|
| | ELSIE | — | MacKENZIE |

2a. DATE OF DEATH: NOVEMBER 28, 1988 (MONTH DAY YEAR) | 2b. HOUR: 3 A M

| 3. SEX | 4. RACE | 5. DATE OF BIRTH (MONTH DAY YEAR) | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| Female | Cauc. | May 21 1902 | 86 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| New York | USA | | Montgomery MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Germantown | 18416 Kings Hill Road | Adm. Assistant | Insurance |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Germantown | YES ☐ NO ☒ | 18416 Kings Hill Rd. 20874 |

| 14. FATHER'S NAME (FIRST MIDDLE LAST) | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) |
|---|---|
| Stewart — MacKenzie | Augusta — Schultz |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | | 065-03-4799 | Faith B. Mackay, | same as # 13 E. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Cardio myopathy
DUE TO, OR AS A CONSEQUENCE OF (c) Mitral insufficiency
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Coronaried

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from June 21, 19 88, to Nov 16, 19 88, that (I) (we) last saw the deceased alive on Nov 16, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN | 22c. DATE SIGNED |
|---|---|---|---|
| | MD | ☐ ☒ ☐ | 11/28/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| MARIO O. BELLEDONNE | 1491C PHYSICIAN LN 251 Rock MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec. 2, 1988 | Fairview Cemetery | Westfield Union New Jersey |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Muriel H. Barber Funeral Home, Laytonsville, Md. 20879 | NOV 30 1988 | Celia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

016000 DEC 13 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

S B 37174
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | Evelyn Bergmann Maire | | | 2a. DATE OF DEATH MONTH DAY YEAR | November 29, 1988 |
| | | | | 2b. HOUR | 6:10 P M |
| 3. SEX | Female | 4. RACE | White | 5. DATE OF BIRTH MONTH DAY YEAR | June 21, 1924 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 64 YRS | IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS. HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Wash.D.C. | 7b. CITIZEN OF WHAT COUNTRY? | USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH | Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 14615 Claude Lane | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Homemaker |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Md. | 13b. COUNTY | Mont. | 13c. CITY OR TOWN | S.S. |
| 13d. INSIDE CITY LIMITS? | YES ☒ NO ☐ | 13e. STREET ADDRESS | 14615 Claude Lane | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | Franz A. Bergmann | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Dorothy Allen | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | N/A | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | 218 12 7813 |
| 17. INFORMANT | Cyril Maire (Husband) | ADDRESS | Same as 13E | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: IMMEDIATE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC ADENOSQUAMOUS CARCINOMA OF UTERUS — 17 months

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from July 18, 19 88, to NOVEMBER 29, 19 88, that (I) (we) last saw the deceased alive on NOV 2, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Mark E. Ellis — DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 11/30/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr.Mark E. Ellis

22e. ADDRESS: 7525 Greenway Court Dr. Greenbelt, Md.

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Burial | 23b. DATE | 12/2/88 | 23c. NAME OF CEMETERY OR CREMATORY: Union Cemetery |
| 23d. LOCATION CITY OR TOWN / COUNTY / STATE | Burtonsville Mont.Md. | | | |
| 24. FUNERAL DIRECTOR | Hines/Rinaldi 11800 New Hampshire Ave. S.S.Md. | | | |
| 25a. DATE REC'D. BY REGISTRAR | DEC 2 88 | 25b. REGISTRAR | Gina Gordon-Rinaldi | |

BP

DHMH - 1650M 1/81 (VRA 15, 4)

577-05-2428
014447 NOV 25 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37175 REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Elizabeth | MIDDLE: C, | LAST: Malcolm | 2a. DATE OF DEATH MONTH DAY YEAR: Nov., 20, 1988 | | 2b. HOUR: 10 45 AM |
| 3. SEX: F | 4. RACE: W | 5. DATE OF BIRTH MONTH DAY YEAR: 5- 19- 1907 | 6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina | 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery. MD. | | |
| 10. CITY OR TOWN OF DEATH: Silver Spring. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 17305 Twin RidgeCt. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): General Counting. | 12b. KIND OF BUSINESS OR INDUSTRY: Retired. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md. | 13b. COUNTY: Montg. | 13c. CITY OR TOWN: Silver Spring | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 17305 Twin Ridge Ct. | |
| 14. FATHER'S NAME FIRST: Unknown | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST: Unknown . | MIDDLE | LAST |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No. | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 577-05-2428 | 17. INFORMANT: Essie Riemer. | ADDRESS: Silver Sprg. Md. 13140 Columbia Pike. | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | cardiac arrst | 3 minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | arterio sclerosis | 10 years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | advanced age | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: — | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: — | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from May, 19 84, to 20 Nov, 19 88, that (I) (we) last saw the deceased alive on 17 Nov 88, 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: Carol Jean Smith, MD | DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 20 Nov 88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): CAROL JEAN Smith, MD | 22e. ADDRESS: 13823 Outlet Dr, Silver Spring, Md. 20904 | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT): Burial. | 23b. DATE: Nov. 22, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: Union Cemetery. | 23d. LOCATION CITY OR TOWN: Burtonsville, Md. COUNTY: Montg. Co. STATE | |
| 24. FUNERAL DIRECTOR: J. Arthur Walters | Takoma Funeral Home. 254 Carroll St. N. W. D. C. | 25a. DATE REC'D. BY REGISTRAR: NOV 22 1988 | 25b. REGISTRAR'S SIGNATURE: | |

254

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

013118 NOV 15 88

1- FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37176 REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | 2b. HOUR |
|---|---|---|---|---|---|
| John | John | W. | Malley | 11 5 88 | 1125 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | IF UNDER 24 HRS |
|---|---|---|---|---|---|
| Male | Cauc. | 2 17 06 | 82 YRS. | MONTHS / DAYS | HOURS / MIN. |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| West Virginia | U.S.A. | MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | Montgomery MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Chevy Chase | Bethesda Retirement + Nursing Ctr. | Attorney | Self-employed |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MD | Montgomery | Chevy Chase | YES ☒ NO ☐ | 24 Quincy Street/20815 |

| 14. FATHER'S NAME | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|---|---|
| | Robert | J. | Malley | | Adelia | A. | Carney |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | | 577-05-2068 | Kathleen M. Montague, Chevy Chase, MD | 3614 Thornapple St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) STROKE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 48 HOURS

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: MULTIINFARCT DEMENTIA

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| ☐ | | |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | | |

22a. I certify that (I / this hospital) attended the deceased from 7/29 19 88 to 11/5 19 88, that (I / we) last saw the deceased alive on 11/5 19 88, and that in (my / our) opinion death occurred on the date and hour and from the causes stated above. (I / we) (did / did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Frayne A Voith MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 11/5/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| MARJORIE A. VOITH MD | 5530 WISCONSIN AVE CHEVY CHASE MD #1240 20815 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 11/9/88 | Arlington National Cem. | Arlington, VA |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Joseph Gawler's Sons, Inc. | 5130 Wisconsin Ave, NW, Washington, D.C. 20016 | NOV 10 1988 | Julia Davidson-Bondale |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

015784 DEC 12 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO 37177

1. DECEASED NAME (TYPE OR PRINT): FIRST Albert MIDDLE LAST Mallinger

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ MONTH 12 DAY 3 YEAR 88 19 — 2b. HOUR 3:07 P.M.

3. SEX: male — 4. RACE: white — 5. DATE OF BIRTH: MONTH 7 DAY 28 YEAR 08 — 6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 3 YEAR 88 19 — 2d. HOUR 5:04 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Poland

7b. CITIZEN OF WHAT COUNTRY? U.S.A

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Presser

12b. KIND OF BUSINESS OR INDUSTRY: Clothing Co.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Montgomery — 13c. CITY OR TOWN: Germantown — 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e. STREET ADDRESS: 19500 Crystle Rock Dr.,#12 (20874)

14. FATHER'S NAME: FIRST Max MIDDLE LAST Mallinger

15. MOTHER'S MAIDEN NAME: FIRST Anna MIDDLE LAST Mallinger

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES): ----------

16b. SOCIAL SECURITY NO.: 344-18-2508

17. INFORMANT ADDRESS: Arnold J. Mallinger; Nephew; 20405 Aspenwood Lane; Gaithersburg, Md. 20879

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio Respiratory Arrest

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Hypothermia

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH 12 DAY 2 YEAR 88 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Fell from Wheelchair.

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): Home

21f. LOCATION STREET 19500 Crystal Rock Dr #12 CITY OR TOWN Montgomery COUNTY Md STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John Tauber — TITLE (SPECIFY): M.D. MEDICAL EXAMINER — DATE SIGNED 12-4-88

EXAMINER'S NAME (TYPE OR PRINT): John Tauber — ADDRESS 8218 Wisconsin Ave Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 12/6/88 — 23c. NAME OF CEMETERY OR CREMATORY: Myrtle Hill Cemetery — 23d. LOCATION CITY OR TOWN: Tampa, Florida COUNTY STATE

24. FUNERAL DIRECTOR NAME: DANZANSKY-GOLDBERG MEMORIAL CHAPELS — ADDRESS: 1170 Rockville Pike; Rockville, Md. 20852

25a. DATE REC'D BY REGISTRAR: DEC 09 1988 — 25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGES SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

014679 NOV 3 1988 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 7178

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: MARK | MIDDLE: David | LAST: Mann | 2a. DATE OF DEATH KNOWN XX ESTIMATED ☐ MONTH DAY YEAR: 11-20-88 | 2b. HOUR: M | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Oct. 29, 1946 | 6. AGE (IN YEARS LAST BIRTHDAY): 42 YRS. | IF UNDER 1 YR. MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 11-20-19 88 | 2d. HOUR: 6:20P M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York | 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD | | | |
| 10. CITY OR TOWN OF DEATH: Olney | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Principal | 12b. KIND OF BUSINESS OR INDUSTRY: Public Schools | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Montgomery | 13c. CITY OR TOWN: Rockville | 13d. INSIDE CITY LIMITS? YES XX NO ☐ | 13e. STREET ADDRESS: 14322 Yosemite Court 20853 | | |
| 14. FATHER'S NAME FIRST: Dr. Norman | MIDDLE: E. | LAST: Mann | 15. MOTHER'S MAIDEN NAME FIRST: Sivia | MIDDLE | LAST: Brenner | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 559-66-7240 | 17. INFORMANT: Ellen S. Mann (Same as # 13) | ADDRESS | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple injuries
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES XX NO ☐ |
| 21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: 6:00PM 11-20-19 88 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Driver in auto/pick-up truck collision |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): in auto | 21f. LOCATION STREET: Bauer Drive at Greenspan Lane, CITY OR TOWN: Rockville, COUNTY: Montgomery County, STATE: MD |

22a. I certify that I took charge of the remains described above, held on Autopsy XX, Inspection ☐, Inquiry ☐ and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Margaret Korell TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED: 11-21-88

EXAMINER'S NAME (TYPE OR PRINT): Margarita A. Korell, M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 11/23/1988 | 23c. NAME OF CEMETERY OR CREMATORY: Judean Memorial Gardens | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Olney, Montgomery, Maryland |

24. FUNERAL DIRECTOR NAME AND ADDRESS: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.

25a. DATE REC'D. BY REGISTRAR: NOV 28 1988 25b. REGISTRAR'S SIGNATURE:

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

017579 DEC 30 88

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37179
REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: HELEN | MIDDLE: SCHOFIELD | LAST: MANNING | 2a. DATE OF DEATH MONTH DAY YEAR: 12/8/88 | 2b. HOUR: 11 15AM | |
| 3. SEX: FEMALE | 4. RACE: CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR: OCTOBER 10, 1904 | 6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MASSACHUSETTS | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH: KENSINGTON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 10225 KENSINGTON PARKWAY #303 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): DIRECTOR OF RECREATION | 12b. KIND OF BUSINESS OR INDUSTRY: HUDSON, MA. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE: MARYLAND | 13b. COUNTY: MONTGOMERY | 13c. CITY OR TOWN: KENSINGTON | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET ADDRESS / ZIP CODE: 10225 KENSINGTON PARKWAY #303 20895 | |
| 14. FATHER'S NAME FIRST: WILLIAM | MIDDLE: J. | LAST: SCHOFIELD | 15. MOTHER'S MAIDEN NAME FIRST: MARGARET | MIDDLE: | LAST: O'MALLEY |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES): | 16b. SOCIAL SECURITY NO.: 030-18-7346 | 17. INFORMANT: ALICE J. MANNING | ADDRESS: DAUGHTER SAME AS 13 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of colon — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 13 months
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Arteriosclerotic Heart Disease

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from June 9, 19 87, to Dec 8, 19 88, that (I) (we) last saw the deceased alive on Sept 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: M.D ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/8/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): BLAINE H. EIG — 22e. ADDRESS: 9701 Georgia Ave Silver Spring Md 20902

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: Dec. 13, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: ST. MICHAELS CEMETERY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: HUDSON MIDDLESEX MASSACHUSETTS |
| 24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR. ADDRESS: 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901 | | 25a. DATE REC'D. BY REGISTRAR: DEC 12 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson Goodale |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 6

DHMH - 16 60M 7/84
(VRA 15, 4)

018451 JAN -9 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37180 REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Rose Mary | | Manning | 12 - 18 - 88 | 3:35 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Female | Caucasian | Sept. 1, 1904 | 84 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Poland | United States | | Montgomery County, MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Rockville | Rockville Nursing Home | Homemaker | Own Home |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Montgomery | Chevy Chase | YES ☐ NO ☒ | 7109 Georgia Street/20815 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| not | available | | not | available | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | 090-01-6893 | Robert Edward Manning | 106 N.Van Buren St. Rockville, MD 20850 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 8-7, 19 87, to 12-13, 19 88, that (I) (last) saw the deceased alive on 11-13, 19 88, and that in (my) (opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | 22c. DATE SIGNED |
|---|---|---|---|---|
| John Lowber | MD | ATTENDING PHYSICIAN ☒ | MEDICAL DIRECTOR ☐ | STAFF PHYSICIAN ☐ | 12-28-88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| John Lowber | 8218 Wisconsin Ave. Bethesda Md |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 1988 December 20, | Parklawn Memorial Park | Rockville, Maryland |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25. DATE FILED | 25b. REGISTRAR |
|---|---|---|---|
| Robert A. Pumphrey Funeral Home/ Rockville, Inc. | 300 West Montgomery Ave. Rockville, MD 20850 | DEC 19 88 | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 15

DHMH - 16 50M 4/83 (VRA 15, 4)

015972 DEC 13

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 37181

1. DECEASED NAME (TYPE OR PRINT): FIRST WILLIAM MIDDLE FRANCIS LAST MANNS
2a. DATE OF DEATH: MONTH DECEMBER DAY 4 YEAR 1988
2b. HOUR: 9:51 A M
3. SEX: MALE
4. RACE: CAUCASIAN
5. DATE OF BIRTH: MONTH MARCH DAY 11 YEAR 1925
6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK
7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: BETHESDA
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED
12b. KIND OF BUSINESS OR INDUSTRY: U.S.NAVY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: VIRGINIA
13b. COUNTY: PRINCE WM.
13c. CITY OR TOWN: WOODBRIDGE
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS: 1504 MARYLAND AVENUE 22191

14. FATHER'S NAME: FIRST WILLIAM MIDDLE JOSEPH LAST MANNS
15. MOTHER'S MAIDEN NAME: FIRST CATHERINE MIDDLE GRIFFIN LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES
(IF YES, GIVE WAR OR DATES): 1941-1972
16b. SOCIAL SECURITY NO.: 025-16-1466
17. INFORMANT ADDRESS: MARGARET MANNS,1504 MARYLAND AVENUE

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — WOODBRIDGE, VA 22191

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): METASTATIC ESOPHAGEAL CANCER — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 3, 1988, to DECEMBER 4, 1988, that (I) (we) last saw the deceased alive on DECEMBER 4, 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: W.L. Dahut MD — DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]
22c. DATE SIGNED: 3 Dec 88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): W.L.DAHUT, LT, MC, USNR
22e. ADDRESS: NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Dec. 8, 1988
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION ADDRESS OR CITY OR TOWN: Arlington, Virgin

24. FUNERAL DIRECTOR NAME AND ADDRESS: Mountcastle Funeral Home, 4143 Dale Blvd. Dale City, Virginia
25a. DATE REC'D BY REGISTRAR: DEC 12 1988
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landrum

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

014683 NOV 30 88

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

33 37182
REG. NO.

1- FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT): FIRST DANIEL MIDDLE LAST MARGOLIS

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ MONTH 11 DAY 24 YEAR 1988

2b. HOUR 9:16 P M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: MONTH 5 DAY 12 YEAR 34

6. AGE (IN YEARS LAST BIRTHDAY): 54 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 11 DAY 24 YEAR 1988

2d. HOUR 9:40 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maine

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ XX WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD

10. CITY OR TOWN OF DEATH: BETHESDA

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SUBURBAN HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Travel Agent

12b. KIND OF BUSINESS OR INDUSTRY: Travel Indust

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Rockville

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 11112 Arroyo Drive (20852)

14. FATHER'S NAME FIRST Maurice MIDDLE LAST Margolis

15. MOTHER'S MAIDEN NAME FIRST Miriam MIDDLE LAST Adam

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes

16b. (IF YES, GIVE WAR OR DATES): Korean

16b. SOCIAL SECURITY NO.: 217-30-6893

17. INFORMANT ADDRESS: Solomon Margolis; Brother; 11112 Arroyo Drive Rockville, Md. 20852

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): meta static Melanoma.
Conditions, if any, which gove rise to immediate couse (a) stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: John Tauber M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 11-27-88

EXAMINER'S NAME (TYPE OR PRINT): John Tauber ADDRESS: 8218 Wisconsin Ave Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 11/27/88

23c. NAME OF CEMETERY OR CREMATORY: King David Mem. Garden

23d. LOCATION CITY OR TOWN: Falls Church; COUNTY: Fairfax; STATE: Va.

24. FUNERAL DIRECTOR NAME: DANZANSKY-GOLDBERG MEMORIAL CHAPELS
1170 Rockville Pike; Rockville, Md. 20852

25a. DATE REC'D BY REGISTRAR: NOV 28 1988

REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE IN WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

016212 DEC 15 88 dr

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 37183

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-removal permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST: Emanuel | MIDDLE: N. | LAST: Margolius | 2a. DATE OF DEATH: MONTH Dec | DAY 1 | YEAR 1988 | 2b. HOUR 1035 M |
| 3. SEX: Male | 4. RACE: Caucasian | 5. DATE OF BIRTH: MONTH Jan. DAY 15 YEAR 1904 | 6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH: Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Business Owner (Ret.) Builder | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: ------ | 13b. COUNTY: ---- | 13c. CITY OR TOWN: Washington, DC | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET ADDRESS: 4201 Cathedral Ave., N.W. #802E (20016) | | | |
| 14. FATHER'S NAME: FIRST Wolf MIDDLE LAST Margolius | 15. MOTHER'S MAIDEN NAME: FIRST Jennie MIDDLE LAST Cohen | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | 16b. IF YES, GIVE WAR OR DATES: ---------- | 16b. SOCIAL SECURITY NO.: 578-09-4146 | 17. INFORMANT: Lillian Margolius; Wife; 4201 Cathedral Ave., N.W., #802E; Wash., D.C. ADDRESS | | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE 1a) | CARDIAC ARREST | Minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Congestive Heart Failure | Hours |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Coronary Artery Disease | UNKnown. |

Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 12-2-88, 19 88 to 12-1-88, 19 88, that (I) (we) last saw the deceased alive on 12-1-88, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Joseph A Vassallo | DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED: 12-2-88 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOSEPH A VASSALLO | 22e. ADDRESS: 5530 WISCONSIN Ave Chev Chase MD | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/4/88 | 23c. NAME OF CEMETERY OR CREMATORY: Adas Israel Cong. Cemetery; Washington D.C. | 23d. LOCATION CITY OR TOWN / COUNTY / STATE | |
| 24. FUNERAL DIRECTOR NAME: DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS: 1170 Rockville Pike; Rockville, Md. 20852 | 25a. DATE REC'D. BY REGISTRAR: DEC 6 1988 | 25b. REGISTRAR'S SIGNATURE: Barbara Deardorff Randall | | |

BP

DHMH (16 50M 1/81) (VRA 15, 4)

016773 DEC 20 88

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR 1- STATE REGISTRAR — REG NO. 7184

1. DECEASED NAME (TYPE OR PRINT): FIRST MAE; MIDDLE; LAST MARKS

2a. DATE KNOWN OF DEATH ☑ / ESTIMATED ☐: MONTH 12 DAY 11 YEAR 19 88 — 2b. HOUR 1635 M

3. SEX: Female — 4. RACE: Cauc. — 5. DATE OF BIRTH: MONTH 4 DAY 09 YEAR 08 — 6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN

2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 11 YEAR 19 88 — 2d. HOUR 1635 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York — 7b. CITIZEN OF WHAT COUNTRY? U.S.A. — 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: BETHESDA — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SUBURBAN HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker — 12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD — 13b. COUNTY: MONTGOMERY — 13c. CITY OR TOWN: ROCKVILLE — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 257 CONGRESSIONAL LN (20852)

14. FATHER'S NAME: FIRST David; MIDDLE; LAST Zlattner

15. MOTHER'S MAIDEN NAME: FIRST Bessie; MIDDLE; LAST Bidder

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES): ---------- — 16b. SOCIAL SECURITY NO.: 127-10-8993

17. INFORMANT: Emanuel Marks; Husband; 257 Congressional Lane; Rockville, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ACUTE

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — INDEF

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. 1600 MONTH 12 DAY 11 YEAR 19 88 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): COLLAPSED AT HOME

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): HOME — 21f. LOCATION STREET 257 CONGRESSIONAL LN CITY OR TOWN ROCKVILLE COUNTY MONT STATE MD

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Emanuel Marks M.D. — TITLE (SPECIFY): DEPT MEDICAL EXAMINER — DATE SIGNED 12/11/88

EXAMINER'S NAME (TYPE OR PRINT): FRANCIS C MOYLE — ADDRESS 8200 Wisconsin Ave Bethesda Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 12/14/88 — 23c. NAME OF CEMETERY OR CREMATORY: Judean Memorial Gardens — 23d. LOCATION CITY OR TOWN Olney; COUNTY Montgomery; STATE Maryland

24. FUNERAL DIRECTOR NAME: DANZANSKY-GOLDBERG MEMORIAL CHAPELS — ADDRESS: 1170 Rockville Pike; Rockville, Md. 20852

25a. DATE REC'D. BY REGISTRAR: DEC 19 1988 — 25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/88 BR 25M

DHMH - 17
(VR AT5 ME (5))

17806 DEC 30 88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 371 85

| 1. DECEASED NAME (TYPE OR PRINT) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Reuben | E. | Marks, Sr. | December 12, 1988 | 6:45 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH Month Day Year | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS Hours / Min. |
|---|---|---|---|---|---|
| Male | Black | September 18, 1918 | 70 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Virginia | United States | | Bethesda of Columbia MD |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Bethesda | Bethesda Retirement Nursing Center | Electr. Contractor | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| 8700 Jones Mill Road | Mont | Chevy Chase | YES X NO ☐ | 2001 Spruce Drive, N.W. 20815 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Thomas | | Marks | Fannie | | Hicks |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | 2/8/43-1/12/46 | 231-05-0831 | Johnella Marks-Wife | 2001 Spruce Drive, N.W. Wash, D.C. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | Approximate interval between onset and death |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiopulmonary arrest | mnt |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Cerebral thrombosis | 48 hrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) | diabetes mellitus | years |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

hypertensive cardiovascular disease

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 12/5 19 86 to 12/12 19 88 that (I) (we) last saw the deceased alive on 19 and that to the (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/12/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Morton W. Shapiro, M.D. | 5225 Pooks Hill Road, Bethesda, MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | December 17, 1988 | Ft. Lincoln Cemetery | Brentwood, MD |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| John S. Stewart III Stewart Funeral Home 4001 Benning Rd. N.E. | DEC 28 1988 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

Property of
Public Library

18272 JAN -6 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37186 REG. NO

| DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Violet | R. | Markward | December 31, 1988 | 7:00 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
|---|---|---|---|---|---|
| Female | White | October 22, 1900 | 88 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Washington, DC | United States | | Montgomery County MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Silver Spring | 10000 Brunswick Avenue, #223 | Homemaker | Own Home |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Montgomery | Silver Spring | YES ☐ NO ☒ | #223 10000 Brunswick Avenue / 20910 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Joseph | | Rupple | Mary | Celestia | Sweeney |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 226-70-1336 | Jean M. Debnam, | 2611 Hughes Road Adelphi, MD 20783 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure — Years

DUE TO, OR AS A CONSEQUENCE OF (c) Cardiomyopathy — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Renal Insufficiency

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 12-31-87 to 12-31-88 that (I) (we) saw the deceased alive on 12-31-88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE S Gupta — DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED January 1, 1989

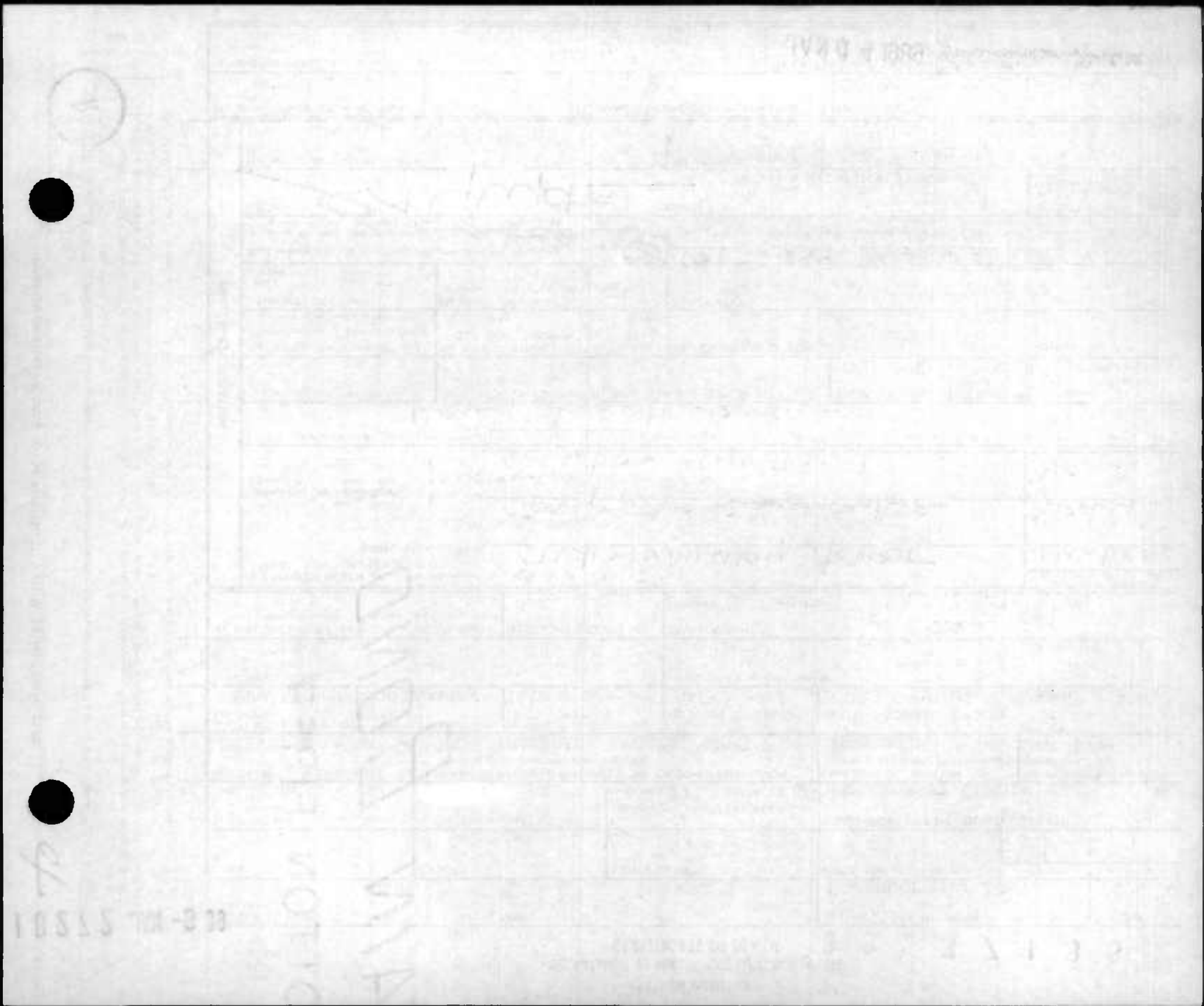
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Suresh K. Gupta, M. D. | 9801 Georgia Avenue, #220 Silver Spring, MD 20902 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Cremation | 1-1-89 | Suburban Crematory | Silver Spring, Maryland |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 | JAN 04 1989 | Gina Davidson-Randall |

BP

DHMH - 16 60M 7/84 (VRA 15, 4)



014110 NOV 22 88 P FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 37187

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Paulette | May | Marthinuss | Nov. 17 1988 | 1245 P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
|---|---|---|---|---|---|
| Female | White | 5 09 44 | 44 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Virginia | USA | | Montgomery MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Silver Spring | Holy Cross Hospital | Adm. Asst. | Martin Mariott Co. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Silver Spring | YES ☒ NO ☐ | 13249 Osterport Dr. 20906 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| William | F. | McCall | (Addie) Lydia | A. | Carr |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (husband) ADDRESS |
|---|---|---|---|
| N/A | N/A | 223-60-0900 | George L. Marthinuss, Jr. (same as 13e) |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardio Respiratory Arrest | minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Metastatic Oat Cell Carcinoma | 2 mos |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| ☐ | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 1986 to Present 19 88, that (I) (we) last saw the deceased alive on 11/17 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DECEASED ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|
| [signature] | | 11/19/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Daniel J. Boyle, MD | 10313 Georgia Ave., Silver Spring, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Nov. 21, 1988 | Gate of Heaven | Silver Spring Montgomery Md. |

| 24. FUNERAL DIRECTOR (NAME AND ADDRESS) | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Hines/Rinaldi Funeral Home 11800 N.H. Ave. Silver Spring, Md. | NOV 18 1988 | Julia Davidson-Kendall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if the death follows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1650M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 037183

01226 NOV 488

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Annie — MIDDLE: L. — LAST: Martin
2a. DATE OF DEATH — MONTH DAY YEAR: 11-1-1988
2b. HOUR: 0115 A.M.
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH — MONTH DAY YEAR: 11 3 16
6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS.
IF UNDER 1 YEAR — MONTHS / DAYS
IF UNDER 24 HRS. — HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): N.C.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD
10. CITY OR TOWN OF DEATH: Takoma Park
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife
12b. KIND OF BUSINESS OR INDUSTRY: own home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Sil. Spr.
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE: 9737 Mt. Pisgah Rd. #1406 20903

14. FATHER'S NAME — FIRST: William — MIDDLE: G. — LAST: Eatmon
15. MOTHER'S MAIDEN NAME — FIRST: Katie — MIDDLE: — LAST: Ballard
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A
16b. (IF YES, GIVE WAR OR DATES): N/A
16b. SOCIAL SECURITY NO: 231-01-5955
17. INFORMANT: James Martin-son- — ADDRESS: 9135 Sam Owings Pl. Owings, Md. 20736

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO, OR AS A CONSEQUENCE OF (b): Pulmonary Embolism — Minutes
DUE TO, OR AS A CONSEQUENCE OF (c): Malignant Mullerian Duct Tumor — Weeks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY Ooccurred (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I (Other hospital) attended the deceased from 22 Sept 19 88 to 1 Nov 19 88, that (I (we) last saw the deceased alive on 31 Oct 19 88, and that (to the best of my (our) knowledge) death occurred on the date and hour and from the causes stated above. (I (We) did (did not) perform the body after death.)
22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 11/1/88
22d. NAME OF PHYSICIAN (TYPE OR PRINT): T A Bensinger MD
22e. ADDRESS: 7625 Greenway Ctr Dr. Greenbelt MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 11-5-1988
23c. NAME OF CEMETERY OR CREMATORY: Pine View Cemetery
23d. LOCATION — CITY OR TOWN: Rocky Mt. — COUNTY: N.Car. 20970
24. FUNERAL DIRECTOR — NAME: Hines/Rinaldi Funeral Home — ADDRESS: 11800 N.M. Ave., Sil. Spring, Md.
25a. DATE REC'D. BY REGISTRAR: NOV 3 1988
25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

019750 JAN 0 3 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 37189

1. DECEASED NAME (TYPE OR PRINT): First: Esther; Middle: K.; Last: Martin

2a. DATE OF DEATH (Month, Day, Year): December 26, 1988

2b. HOUR: 9:00 P.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH (Month, Day, Year): Jan. 8, 1896

6. AGE (In years last birthday): 92 YRS.

If under 1 year: Months / Days

If under 24 hrs.: Hours / Min.

7a. BIRTHPLACE (State or Foreign Country): Wash. D.C.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address): Bethesda Retirement Center

12a. USUAL OCCUPATION (Type of work for most of working life): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (If nursing home or other institution, give residence before admission)

13a. STATE: Maryland

13b. COUNTY: Mont.

13c. CITY OR TOWN: Bethesda

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 9313 East Park Hill Dr. 20814

14. FATHER'S NAME: First: John; Middle: S.; Last: Killmon

15. MOTHER'S MAIDEN NAME: First: Eva; Middle: A.; Last: DeBall

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown; if yes, give war or dates): no

16b. SOCIAL SECURITY NO.: 218-54-6917

17. INFORMANT ADDRESS: Son - Dean H. Martin 1709 Oaklane La., McLean, Va.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a), b), and c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Right Hemispheric Stroke

DUE TO, OR AS A CONSEQUENCE OF (b): Acute Cerebral Hemorrhage

DUE TO, OR AS A CONSEQUENCE OF (c): Cerebral Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Approximate interval between onset and death: 4 days.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Adenocarcinoma Sigmoid Colon with Hepatic Metastases.

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify Medical Examiner)

21b. TIME OF INJURY: Hour A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part I or Part 2):

21d. INJURY OCCURRED: While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (At home, street, factory, office, farm, etc.):

21f. LOCATION: Street; City or Town; County; State

22a. I certify that (I) (this hospital) attended the deceased from July 19 66 to 12/26 19 88 that (I) (last saw the deceased alive on 12/14 19 88) and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (practical void and) view the body after death.

22b. SIGNATURE: J. Blaine Fitzgerald, M.D. DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: Dec. 26'88

22d. PHYSICIAN'S NAME (Type or Print): J. Blaine Fitzgerald, M.D.

22e. ADDRESS: 8218 Wisc. Ave., Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Dec. 30'88

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

23d. LOCATION: City or Town: Brentwood, Md.; County; State

24. FUNERAL DIRECTOR: DeVol Funeral Home, Washington, D.C.

25a. DATE REC'D. BY REGISTRAR: DEC 29'88

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rondeau

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then release remaining carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

BP 6

DHMH - 16 60M 7/84
(VRA 15, 4)

96007 DEC 13 88

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 37190

| 1. DECEASED NAME (TYPE OR PRINT) | FIRST | MIDDLE | LAST |
|---|---|---|---|
| | Joseph | James | Martin |

2a. DATE OF DEATH: MONTH Dec DAY 3 YEAR 88 — 2b. HOUR 5:45 AM

| 3. SEX | 4. RACE | 5. DATE OF BIRTH (MONTH DAY YEAR) | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
|---|---|---|---|---|---|
| Male | Caucasian | Sept. 13, 1909 | 79 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Pennsylvania | United States | | Montgomery County, MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Rockville | SHADY GROVE ADVENTIST HOSPITAL | Civil Servant | US Government |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Rockville | YES ☒ NO ☐ | 22 Harvard Court/20850 |

| 14. FATHER'S NAME (FIRST MIDDLE LAST) | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) |
|---|---|
| Owen Martin | Jessie Glendenning |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WW II | 177-05-7890 | James Martin, same as #13 | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiogenic shock — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3hours

DUE TO, OR AS A CONSEQUENCE OF

(b) Cirrhosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from Nov 30, 19 88, to Dec 3, 19 88, that (I) (we) last saw the deceased alive on Dec 3, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
|---|---|---|---|
| Mark S Rosen | MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 12/3/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Mark Rosen | Silver Spring, MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Dec. 10, 1988 | Cathedral Cemetery | Scranton, Pennsylvania |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Robert A. Pumphrey Funeral Home/ Rockville, Inc. | 300 West Montgomery Ave. Rockville, MD 20850 | DEC 5 '88 | Julia Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by [illegible] and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please [illegible] pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other [illegible] event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 201

DHMH - 16 50M 1/81 (VRA 15, 4)

014764 NOV 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 REG. NO. 37191

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Lenora (LeNoRA) MIDDLE: S. LAST: Sponseller Martin (Martin) | | | | 2a. DATE OF DEATH MONTH DAY YEAR: 11/15/88 | 2b. HOUR: 10:15 AM |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: June 27, 1899 | 6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WV | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery | | MD. |
| 10. CITY OR TOWN OF DEATH: GaithersBurg | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): ASBury Methodist Village | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Secretary | 12b. KIND OF BUSINESS OR INDUSTRY: Riggs Nat'l. Bank | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD | 13b. COUNTY: Mont. | 13c. CITY OR TOWN: Chevy Chase | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS / ZIP CODE: 7106 Fulton St. 20815 | |
| 14. FATHER'S NAME FIRST: Edgar MIDDLE: R. LAST: Sponseller | | 15. MOTHER'S MAIDEN NAME FIRST: Clara MIDDLE: Virginia LAST: Burton | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 220-34-3470 | 17. INFORMANT ADDRESS: Robert Martin 180 Cook St. #110 Denver CO 80206 | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Pneumonia | 1 week |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Multiple Thrombotic Strokes | 1 year |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Arteriosclerotic Cerebrovascular Disease | 10 years |

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Carcinoma of Breast; Arteriosclerotic Heart Disease

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify thot (I) ~~(this hospitol)~~ attended the deceased from March, 19 88, to 15 November, 19 88, thot ~~(I)~~ (we) lost sow the deceased olive on 15 November 19 88, and thot in (my) ~~(our)~~ opinion deoth occurred on the dote ond hour ond from the couses stoted above, ~~(I)~~ (we) (did) ~~(did not)~~ view the body ofter deoth.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: John F. Gustafson | DEGREE: M.D. ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: November 15, 1988 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): John F. Gustafson, M.D. | 22e. ADDRESS: 5480 Wisconsin Avenue Chevy Chase, MD. 20815-3595 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 11-23-88 | 23c. NAME OF CEMETERY OR CREMATORY: Fairview Lutheran Cem. | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Boliver, WV | |
| 24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons, Inc. ADDRESS: 5130 WI Ave. NW Wash., DC 20016 | | 25a. DATE REC'D. BY REGISTRAR: NOV 28 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson Rendelle | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires thot the deoth certificote be executed within 24 hours ofter deoth. Page 4 moy be retoined by the hospitol or ottending physicion.

TO FUNERAL DIRECTOR: After this certificote hos been signed by the ottending physicion ond completely filled in by the funerol director, page 3 should be detoched for use of the burial-transit permit. Then pleose remove corbon popers. Pages 1 ond 2 should be filed within 72 hours after deoth with the State Dept. of Heolth ond Mentol Hygiene prior to buriol, cremotion, or removol.

IMPORTANT: If item 21 is morked or item 18 shows ony injury, or other troumotic event, the medicol exominer must be notified ot once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

| | | | | | | |
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014530 NOV 28 88 FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

B 3 REG. NO. 37192

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: EMMA | MIDDLE: GLADYS | LAST: MATHERS | 2a. DATE OF DEATH MONTH DAY YEAR: NOVEMBER 17, 1988 | 2b. HOUR: 1:15A.M | |
| 3. SEX: FEMALE | 4. RACE: CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR: JUNE 1, 1907 | 6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH: SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 415 SILVER SPRING AVE. # 402 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER | 12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE: MARYLAND | 13b. COUNTY: MONTGOMERY | 13c. CITY OR TOWN: SILVER SPRING | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET ADDRESS: 415 SILVER SPRING AVE. # 402 | 20910 |
| 14. FATHER'S NAME FIRST: ALBERT | MIDDLE | LAST: HAEGERICH | 15. MOTHER'S MAIDEN NAME FIRST: HELENA | MIDDLE | LAST: WESTENHOFER |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 215-07-2926 | 17. INFORMANT: AUDREY J. FUNK | ADDRESS: 30 CHESTER CIR. GLEN BURNIE, MD. 21061 | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Metastatic Breast Cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from July 30, 19 87, to November 15 19 88, that (I) (we) last saw the deceased alive on November 9, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | 22c. DATE SIGNED |
|---|---|---|---|---|
| Jeffrey M. Crane | MD | ATTENDING PHYSICIAN ☒ | MEDICAL DIRECTOR ☐ | STAFF PHYSICIAN ☐ | 11/18/88 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Jeffrey M. Crane | 14808 Physicians Lane #212 Rockville MD 20850 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | NOV. 21, 1988 | GLEN HAVEN CEMETERY | GLEN BURNIE MARYLAND |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD. W. SILVER SPRING, MD. 20901 | NOV 23 1988 | [signature] |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of date.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1650M 1/81 (VRA 15, 4)

014293 NOV 23-88

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 37193

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Edward — MIDDLE: — LAST: Matthews

2a. DATE KNOWN OF DEATH / ESTIMATED — MONTH: Nov. — DAY: 20 — YEAR: 1988

2b. HOUR: 1015 A.M.

3. SEX: M

4. RACE: Blk

5. DATE OF BIRTH — MONTH: Aug — DAY: 25 — YEAR: 37

6. AGE (IN YEARS LAST BIRTHDAY): 51 YRS. — IF UNDER 1 YR. MONTHS: — DAYS: — IF UNDER 24 HRS. HOURS: — MIN:

2c. DATE PRONOUNCED DEAD — MONTH: Nov — DAY: 20 — YEAR: 1988

2d. HOUR: 1045 A.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash., D. C.

7b. CITIZEN OF WHAT COUNTRY?: U. S. A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD

10. CITY OR TOWN OF DEATH: Silver Spg

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital, Leder Rd

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Supervisor Med. Rec.

12b. KIND OF BUSINESS OR INDUSTRY: Hospital

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md

13b. COUNTY: Mont.

13c. CITY OR TOWN: Silver Spg

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 10105 Leder Rd 2992

14. FATHER'S NAME — FIRST: Benjamin — MIDDLE: O. — LAST: Matthews

15. MOTHER'S MAIDEN NAME — FIRST: Elizabeth — MIDDLE: — LAST: Hawkins

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 578-52-9091

17. INFORMANT — ADDRESS: Elizabeth H. Matthews-10105 Leder Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Dis.

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Myocardial Dis.

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: [signature] M.D. — TITLE (SPECIFY): MEDICAL EXAMINER — DATE SIGNED: Nov 20, 1988

EXAMINER'S NAME (TYPE OR PRINT): _____ ADDRESS: _____

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 11-25-88

23c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial Cemetery

23d. LOCATION CITY OR TOWN: Suitland, P. G. COUNTY: Md. STATE:

24. FUNERAL DIRECTOR NAME: T. C. Pinckney — ADDRESS: Spangler Funeral Home 524-8th St., N. E. DC

25a. DATE REC'D. BY REGISTRAR: NOV 22 1988

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randolph

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

012805 NOV 14 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, date of traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

1 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

REG. NO. 88 37194

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: HARRY FONSOE MAYBERRY, SR. | | | 2a. DATE OF DEATH MONTH DAY YEAR: NOVEMBER 2 1988 | 2b. HOUR: 10:50 PM |
| 3. SEX: MALE | 4. RACE: BLACK | 5. DATE OF BIRTH MONTH DAY YEAR: MARCH 1 1939 | 6. AGE (IN YEARS LAST BIRTHDAY): 49 YRS | # UNDER 1 YEAR: MONTHS / DAYS; # UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MISSOURI | 7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH: BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY: U.S. ARMY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: VIRGINIA | 13b. COUNTY: FAIRFAX | 13c. CITY OR TOWN: Newington | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET ADDRESS: 8297 WOLD DEN COURT 22153 |
| 14. FATHER'S NAME FIRST MIDDLE LAST: WALTER MAYBERRY | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: GERALDINE CAHILL | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES | (IF YES, GIVE WAR OR DATES): 1961-1986 | 16b. SOCIAL SECURITY NO.: 492-38-7357 | 17. INFORMANT ADDRESS: ANJA S. MAYBERRY, 8297 WOLD DEN COURT, SPRINGFIELD, VA 22153 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE AORTIC INSUFFICIENCY
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ] | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 1, 19 88, to NOVEMBER 2, 19 88, that (I) (we) last saw the deceased alive on NOVEMBER 2, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: M. S. Georgiadis | DEGREE: MD | ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X] | 22c. DATE SIGNED: 11/3/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): M.S. GEORGIADIS, LT, MC, USNR | | 22e. ADDRESS: NAVAL HOSPITAL BETHESDA, MD 20814-5011 | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Nov. 7, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: Arlington National | 23d. LOCATION CITY OR TOWN: Arlington COUNTY: Virginia STATE: |
| 24. FUNERAL DIRECTOR NAME: Mountcastle Funeral Home ADDRESS: 13318 Occoquan Rd. Woodbridge, VA 2219 | | 25a. DATE REC'D BY REGISTRAR: NOV 9 1988 | 25b. REGISTRAR'S SIGNATURE: |

Item#'s18a,21a,b,c,d,e,f,22a per M.E.cg

D17580 DEC 88

FOR 1- STATE REGISTRAR Film G649 3/31/89

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 88 37195

| | | | | | | |
|---|---|---|---|---|---|---|
| DECEASED NAME (TYPE OR PRINT) | FIRST: Charles | MIDDLE: Everett | LAST: Mc Corkle | 2a. DATE OF DEATH: KNOWN ☐ ESTIMATED XX MONTH 12 DAY 3 YEAR 88 | 2b. HOUR | |
| 3. SEX: MALE | 4. RACE: CAUCASIAN | 5. DATE OF BIRTH: MONTH/DAY/YEAR 1,1955 | 6. AGE (IN YEARS LAST BIRTHDAY): 33 YRS. | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN | 2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 6 YEAR 88 | 2d. HOUR 10:00 A M |

| | | | |
|---|---|---|---|
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): TENNESSEE | 7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD. |
| 10. CITY OR TOWN OF DEATH: Germantown | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 19910 Stoney Point Way | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): VIDEO EDITOR | 12b. KIND OF BUSINESS/INDUSTRY: COMSAT COMMUNICATIONS |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE: MARYLAND | 13b. COUNTY: MONTGOMERY | 13c. CITY OR TOWN: GERMANTOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 19910 STONEY POINT WAY, 20874 |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME: FIRST KENNETH MIDDLE E. LAST Mc CORKLE | | 15. MOTHER'S MAIDEN NAME: FIRST ROSE MARIE MOORE MIDDLE LAST | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 412-02-4859 | 17. INFORMANT: KENNETH E. Mc CORKLE/ | ADDRESS: 3201 JOSLYN STREET MEMPHIS, TENN. 28128 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Amitriptyline intoxication — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES XX NO ☐ |

| | | |
|---|---|---|
| 21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. 12/3 MONTH DAY 1988 YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Subject used drugs. |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): Home | 21f. LOCATION STREET 19910 Stoney Pt. Way CITY OR TOWN Germantown COUNTY Montgomery Co. STATE Md. |

22a. I certify that I took charge of the remains described above, held on Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Charles P. Kokes M.D. TITLE (SPECIFY): Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED: 12-7-88

VC EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes, M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION | 23b. DATE: DECEMBER 8, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: MONTGOMERY CREMATORIUM, INC. | 23d. LOCATION CITY OR TOWN BETHESDA COUNTY MONTGOMERY STATE MD |

| | | |
|---|---|---|
| 24. FUNERAL DIRECTOR NAME: ROBERT A. PUMPHREY FUNERAL HOME, ROCKVILLE, INC. 300 WEST MONTGOMERY AVENUE, ROCKVILLE, MD 20850 | 25a. DATE REC'D. BY REGISTRAR: DEC 9 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-84 25M BP

(VR A15 ME (5))

018450 JAN -9 89

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 37196

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: James | MIDDLE: P. | LAST: McCrystal, Sr. | |
| 2a. DATE OF DEATH MONTH DAY YEAR: December 21, 1988 | 2b. HOUR: 10:58pm | | |
| 3. SEX: Male | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: January 18, 1904 | 6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS; IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Illinois | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD. |
| 10. CITY OR TOWN OF DEATH: Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Meridian Nursing Home | 12a. USUAL OCCUPATION (GIVE KIND OF WORK DONE MOST OF LIFE): Quality Control Inspector | 12b. KIND OF BUSINESS OR INDUSTRY: Chicago Screw Company |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Montgomery | Rockville | YES ☐ NO ☒ | 16637 Frontenac Terrace/20855 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| James | Patrick | McCrystal | Mary | (Unknown) | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (son) ADDRESS |
|---|---|---|---|
| No | N/A | 357-05-8502 | James P. McCrystal, Jr. Same as line #13 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | cardiorespiratory arrest | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Renal Failure | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Metastatic cancer of prostate

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from July 7, 1988 to Dec. 21, 1988, that (I) (we) last saw the deceased alive on Dec. 19, 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Krishna P. Kumar | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | Dec. 22, 1988 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Krishna Kumar, M.D. | 10802 Hickory Ridge Road, Columbia, MD 21044 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Burial | Dec. 28, 1988 | Forest Home Cemetery | Forest Park, Illinois |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 W. Montgomery Avenue Rockville, Maryland 20850 | DEC 23 '88 | Davidson-Kendall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 16

DHMH - 1650M 1/81 (VRA 15. 4)

018449 JAN -9 89

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 88 37197

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Edith Middle: Mildred Last: McCullough | | | | 2a. DATE OF DEATH Month Day Year: 12/16/88 | 2b. HOUR: 0210 M |
| 3. SEX: female | 4. RACE: Caucasian | 5. DATE OF BIRTH Month Day Year: August 12, 1899 | 6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH: Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Auditor | 12b. KIND OF BUSINESS OR INDUSTRY: Justice Department | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Montgomery | 13c. CITY OR TOWN: Gaithersburg | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: #305 19310 Club House Road 20879 | |
| 14. FATHER'S NAME First: Jesse Middle: H. Last: L'Hommedieu | | | 15. MOTHER'S MAIDEN NAME First: Florence Middle: E. Last: Cornwell | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 577-56-2676 | 17. INFORMANT: Richard C. McCullough Son | ADDRESS: 10963 Deborah Drive, Potomac, MD., 20854 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ESOPHAGEAL VARICEAL HEMORRHAGE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 18 HOURS

DUE TO, OR AS A CONSEQUENCE OF (b): PRIMARY BILIARY CIRRHOSIS — 4 YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CHRONIC LYMPHOCYTIC LEUKEMIA; GRANULOMATOUS LUNG DISEASE

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/15, 19 88, to 12/16, 19 88, that (I) (we) last saw the deceased alive on 12/15, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Alan N. Schulman — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/16/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ALAN N. SCHULMAN — 22e. ADDRESS: 9715 MEDICAL CENTER DRIVE ROCKVILLE, MD. 20850

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation | 23b. DATE: December 17, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: Montgomery Crematorium | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Bethesda, Maryland |

24. FUNERAL DIRECTOR NAME AND ADDRESS: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave. Rockville, Maryland 20850

25a. DATE RECD. BY REGISTRAR: DEC 19 88 — 25b. REGISTRAR'S SIGNATURE: Gene Henderson

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

013121 NOV 15 88

FOR 1- STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 37198

1. DECEASED NAME (TYPE OR PRINT): FIRST Michael; MIDDLE; LAST Mc Eneaney

2a. DATE OF DEATH: KNOWN XX ESTIMATED ☐ MONTH 11 DAY 4 YEAR 19 88 — 2b. HOUR —

3. SEX: MALE — 4. RACE: CAUCASIAN — 5. DATE OF BIRTH: MONTH JAN DAY 19 YEAR 1927 — 6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 11 DAY 4 YEAR 19 88 — 2d. HOUR 5:50P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): IRELAND — 7b. CITIZEN OF WHAT COUNTRY? IRELAND — 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: MOntgomery County MD.

10. CITY OR TOWN OF DEATH: Rockville — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): MAINTENANCE MAN — 12b. KIND OF BUSINESS OR INDUSTRY: AUTOMOBILE

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND — 13b. COUNTY: MONTGOMERY — 13c. CITY OR TOWN: ROCKVILLE — 13d. INSIDE CITY LIMITS? YES XX NO ☐ — 13e. STREET ADDRESS: 2014 HENRY RD. 20851

14. FATHER'S NAME: FIRST PETER; MIDDLE; LAST McENEANEY — 15. MOTHER'S MAIDEN NAME: FIRST SARAH; MIDDLE; LAST KIERNAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO.: 213-46-5376 — 17. INFORMANT: MRS. MARY McENEANEY, ADDRESS 2014 HENRY RD. ROCKVILLE, MD 20851

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Mario F. Golle Jr. — TITLE (SPECIFY) Assistant MEDICAL EXAMINER — DATE SIGNED 11-5-88

EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. — ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: 11-9-88 — 23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEM. — 23d. LOCATION CITY OR TOWN SILVER SPRING, COUNTY MONTGOMERY, STATE MD

24. FUNERAL DIRECTOR NAME AND ADDRESS: TYSON WHEELER FUNERAL HOME, INC. 1331 ROCKVILLE PIKE, ROCKVILLE, MD 20852 — 25a. DATE REC'D. BY REGISTRAR: NOV 10 1988 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Pendarvis

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

012810 NOV 14 88

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

33 REG. NO. 37193

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| PATRICK | | McEVOY | NOVEMBER 6, 1988 | 1:45A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
|---|---|---|---|---|---|
| MALE | CAUCASIAN | APRIL 1 1898 | 90 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| IRELAND | USA | | MONTGOMERY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| ROCKVILLE | SHADY GROVE ADVENTIST HOSPITAL | CONDUCTOR | I.R.T. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MARYLAND | MONTGOMERY | POTOMAC | YES ☐ NO ☐ | 7905 IVYMOUNT TERRACE 20854 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| WILLIAM | | McEVOY | UNKNOWN | | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 067-05-3543 | PATRICK J. McEVOY/SON/SAME AS 13 | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) SEPTICEMIA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 DAY

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA — 1 MONTH

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: ARTERIOSCLEROTIC VASCULAR DISEASE

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) ~~(have attended)~~ attended the deceased from MARCH, 19 88, to ____, 19____, that (I) (~~saw~~ last saw the deceased alive on 4 NOV 19 88, and that in (my) (~~opinion~~ opinion death occurred on the date and hour and from the causes stated above. (I) (~~saw~~ did not) view the body after death.

22b. SIGNATURE Walter E Goozh MD DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 6 NOV 88

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| WALTER E. GOOZH MD | 2309 SHORECLIFF ROAD WHEATON MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| BURIAL | NOV 9,1988 | GATE OF HEAVEN CEM. | SILVER SPRING | MONTGOMERY | MD |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| FRANCIS J. COLLINS, JR. | 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901 | NOV 9 1988 | |

DIVISION OF VITAL RECORDS — 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

016535 DEC 1988

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37200 D

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | Valerie / A. / McGettigan | 2a. DATE OF DEATH MONTH DAY YEAR | December 3, 1988 | 2b. HOUR: 8:30p M |
| 3. SEX | Female | 4. RACE | Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: April 12, 1931 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 57 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY? | United States | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH | Chevy Chase | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 6915 Woodside Place | 12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE): Interior Designer |
| 12b. KIND OF BUSINESS OR INDUSTRY | Own Business | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Maryland | 13b. COUNTY | Montgomery | 13c. CITY OR TOWN: Chevy Chase |
| 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS | 6915 Woodside Place/20815 | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | Stanley / / Jakubowski | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Stephanie / / Matuzewski | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | No | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.: 166-28-2380 |
| 17. INFORMANT ADDRESS | James M. McGettigan 6915 Woodside Place Chevy Chase, Maryland 20815 (Husband) | | | |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC COLON CARCINOMA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 21 mos
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I **certify** that (I) (this hospital) attended the deceased from JUNE 22 19 88, to DECEMBER 3, 19 88, that (I) (~~we~~) last saw the deceased alive on NOVEMBER 30 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~attended~~) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | James A. Brown MD | DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12/5/88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | JAMES A BROWN, MD | 22e. ADDRESS | 14808 PHYSICIANS LANE #212 ROCKVILLE, MD 20850 |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Cremation | 23b. DATE | December 5, 1988 | 23c. NAME OF CEMETERY OR CREMATORY: Montgomery Crematorium Inc. |
| 23d. LOCATION CITY OR TOWN / COUNTY / STATE | Bethesda/Montgomery/Maryland | | | |
| 24. FUNERAL DIRECTOR NAME | Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. | 25a. DATE REC'D BY REGISTRAR | DEC 5 '88 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |
| 7557 Wisconsin Avenue Bethesda, Maryland 20814 | | | | |

BP 16

DHMH - 1650M 1/81
(VRA 15, 4)

016990 DEC 22 88

1. FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

88 37201 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: ARTHUR JAMES MCGOWAN | | | | 2a. DATE OF DEATH MONTH DAY YEAR: DECEMBER 16 1988 | 2b. HOUR: 1:12 P M |
| 3. SEX: MALE | 4. RACE: CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR: MARCH 8 1926 | 6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Massachusetts | 7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH: BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY: U.S.M.C. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: VIRGINIA | 13b. COUNTY: STAFFORD | 13c. CITY OR TOWN: STAFFORD | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET ADDRESS: 205 BOW COVE 22554 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST: JAMES JOSEPH MCGOWAN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: ROSE Finegan | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES | 16b. (IF YES, GIVE WAR OR DATES): 1945-1967 | 16b. SOCIAL SECURITY NO.: 158-14-7705 | 17. INFORMANT ADDRESS: MARGARET P.MCGOWAN,205BOW COVE,STAFFORD,VA | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): RESPIRATORY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 27, 19 88, to DECEMBER 16, 19 88, that (I) (we) last saw the deceased alive on DECEMBER 16, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: S F Penny MD — DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X] | | | 22c. DATE SIGNED: 16 DEC 88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): S. F. PENNY, LT, MC, USNR | 22e. ADDRESS: NAVAL HOSPITAL BETHESDA, MD 20814-5011 | | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Dec.20,1988 | 23c. NAME OF CEMETERY OR CREMATORY: Quantico National | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Triangle, Virginia |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: Mountcastle Funeral Home 13318 Occoquan Rd. Woodbridge, VA | 25a. DATE REC'D. BY REGISTRAR: DEC 21 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH - 1650M 1/81 (VRA 15, 4)

13470 NOV 17 88 1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 37202 REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Grace MIDDLE: Victoria LAST: McGuire | | | | 2a. DATE OF DEATH MONTH DAY YEAR: 11/12/88 | 2b. HOUR: 11:30 AM |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: 1 22 01 | 6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD | | |
| 10. CITY OR TOWN OF DEATH: BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): GROSVENOR HEALTH CARE CENTER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | MONTGOMERY | GAITHERSBURG | YES ☑ NO ☐ | 9343 Weather Vane Place / 20879 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | |
|---|---|---|
| DAVID RICHARD PRICE | SIDNEY M. Mallard | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 272-09-7246 | Lucille Anderson, | Same as 13 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 mos.
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease — 3 years
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic obstructive pulmonary disease

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 5/22 19 88 to 11/12 19 88, that (I) (we) last saw the deceased alive on 11/12 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.

22b. SIGNATURE: Marvin Wadler — DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 11/12/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): M. WADLER — 22e. ADDRESS: 8218 Wise Av Beth. Md.

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 11-16-88 | Niles City Cemetery | Niles, Ohio |

24. FUNERAL DIRECTOR NAME: ~~Reese-Wynn-Winyard-McDermott~~ Funeral Home — ADDRESS: 415 Robbins Avenue, Niles, OH 44446

25a. DATE REC'D. BY REGISTRAR: NOV 15 1988 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3 BP

DHMH - 16 50M 1/81 (VRA 15, 4)